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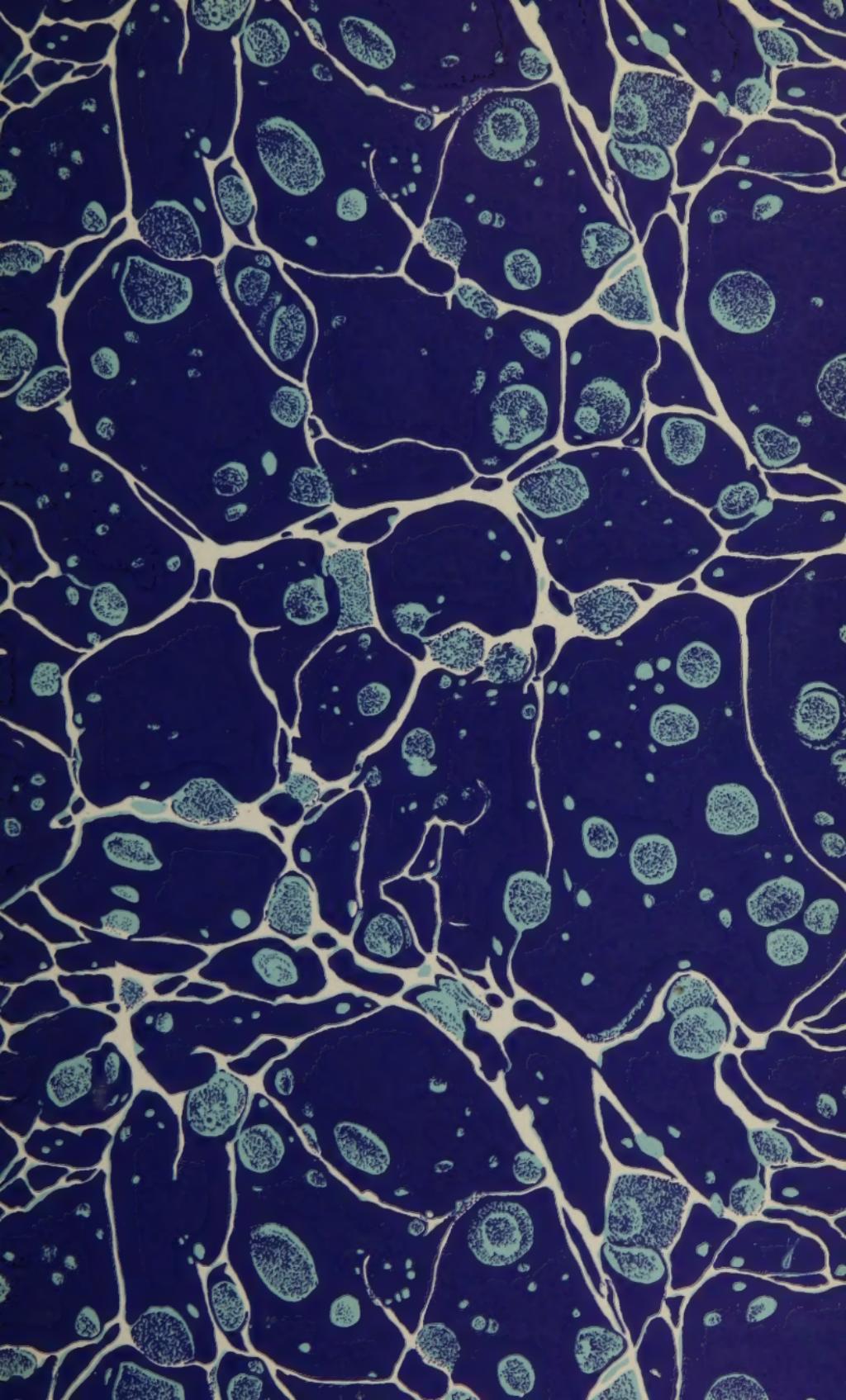
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HUGHES'  
COMPEND OF PRACTICE.

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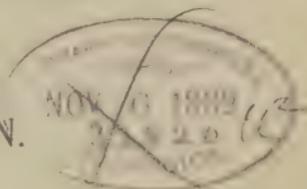
# PRACTICE OF MEDICINE.

BY

DAN'L E. HUGHES, M.D.,

LATE DEMONSTRATOR OF CLINICAL MEDICINE IN THE JEFFERSON MEDICAL COLLEGE  
OF PHILADELPHIA; FELLOW OF THE COLLEGE OF PHYSICIANS  
OF PHILADELPHIA, ETC.

PHYSICIANS' EDITION.



THOROUGHLY REVISED AND ENLARGED.

BASED ON THE FOURTH REVISION OF THE QUIZ COMPEND EDITION,

AND

WITH A VERY COMPLETE SECTION ON SKIN DISEASES

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WASHINGTON, D.C.

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TO  
HIS ESTEEMED FRIEND AND TEACHER,  
**J. M. DA COSTA, M.D.,**  
PROFESSOR OF THE PRACTICE OF MEDICINE  
IN THE  
**JEFFERSON MEDICAL COLLEGE,**  
THIS WORK  
IS RESPECTFULLY DEDICATED BY  
THE AUTHOR.



# PREFACE TO THE PHYSICIANS' EDITION.

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The favor with which the "Compends of the Practice of Medicine," as published in the Quiz-Compend series, have been received, together with the knowledge that many practitioners have made use of them, suggested the advisability of preparing an edition especially for Physicians. To that end the Compends have been thoroughly revised and enlarged, by the incorporation of the more recent improvements in practice and the addition of a very complete section upon Diseases of the Skin, which, with the addition of a complete index, and its publication in one volume, renders it much more convenient for reference.

The exceptional character of the advantages afforded the Author for clinical work, as Demonstrator of Clinical Medicine in the Jefferson Medical College, and also as Assistant-in-charge of the Medical Dispensary of the College Hospital for a number of years, together with his system of notes employed in the Quiz-room during the past five years, have formed the basis of this Compend, which may therefore be regarded as a full set of notes upon the Practice of Medicine.

Free reference has been made to the latest writings and teachings of Professors Da Costa, Bartholow, Pepper, Flint, Loomis, Reynolds, Duhring, Fred. T. Roberts and others, to whom acknowledgment is here made.

DANIEL E. HUGHES.

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## PREFACE TO FOURTH EDITION.

The rapid sale of the previous editions of this book has encouraged the author to make a very complete revision for the fourth edition. This has necessitated the rewriting of many sections and a slight enlargement of the work, so as to include all new methods and discoveries in Diagnosis, Pathology and Treatment. Every effort has been made to keep it as compact as is compatible with clearness, and to make it a thorough guide to the practice of medicine.

D. E. H.

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# COMPEND

OF THE

## PRACTICE OF MEDICINE.

### INTRODUCTION.

The **Principles of Medicine** constitute what may be termed *Medical Science*.

The **Practice of Medicine** is the exercise of medical art, and embraces all that pertains to the knowledge of, prevention and cure of, the diseases which the physician is called upon to treat.

**Disease** may be defined as a deviation or alteration in the functions, properties or structure of some tissue or organ, whereby its office is no longer performed in accordance with the natural standard: *Organic disease*, when associated with an organic change in the affected part; *Functional disease*, when the phenomena are independent of any apparent structural lesion.

The study of disease, whether organic or functional in character, is termed *Pathology*.

*Pathology* explains the *origin, causes, clinical history and nature* of the various morbid conditions to which the economy is liable.

The study of individual diseases constitutes *Special Pathology*; while the study of the morbid conditions common to a greater or less number of diseases, constitutes *General Pathology*.

*Nomenclature*, or the naming of diseases, is a subdivision of general pathology. The value of nomenclature as applied to disease is

that the name chosen shall express the morbid condition involved, as well as its location.

If the morbid condition be an inflammation, the suffix *itis* is added to the anatomical name of the part affected; thus, if the disease be an inflammation of the peritoneum, it is named *peritonitis*.

If the morbid condition is catarrhal, such as a transudation or flux, the liquid escaping upon a mucous surface, the suffix *rhaea* is used; thus, a catarrhal inflammation of the intestinal tract is termed *diarrhaea* and *enterorrhœa*.

If the morbid condition be a flow of blood or hemorrhage from a mucous surface, the suffix *rhagia* is used; thus, a hemorrhage from the small intestines is termed *enterorrhagia*.

If the morbid condition be pain without inflammation, the suffix *algia* is used. The various forms of neuralgias being an example; thus, neuralgia of the stomach is termed *gastralgia*.

If the morbid condition be in the blood, the suffix *aemia* is used. Thus, *Anæmia* is impoverishment of the blood; *Uræmia*, the morbid accumulation of urea in the blood; *Septicæmia*, putrid infection of the blood; *Pyæmia*, purulent infection of the blood.

If the morbid condition is in the urine, the ending *uria* is used to indicate it. *Albuminuria*, when albumin in the urine; *Hæmaturia*, when blood in the urine; *Oxaluria*, when oxalates occur in the urine.

If the morbid condition be a dropsical affection, the prefix *hydro* is added to the part affected. Thus, a dropsical accumulation in the peritoneum is termed *hydro-peritoneum*.

If the morbid condition be that of air in an unnatural part, the prefix *pneumo* to the name of the part is used, as in *pneumo-pericardium*.

If the morbid condition be an inflammation of the membrane investing the part inflamed, the prefix *peri* is made use of. Thus, for an inflammation of the investing membrane of the kidney the term is *perinephritis*.

Inflammation of the connective tissue surrounding an organ is designated by the prefix *para*. Thus, *parametritis* for inflammation of the connective tissue about the womb.

A termination in *oma* signifies a tumor, as in *sarcoma* or *carcinoma*.

The suffix *pathy* is used to designate a morbid condition of a part, without indicating its particular character, an example being the use of the term *encephalopathy*.

**Morbid Anatomy** is the study of the changes in the tissues and fluids of the body appreciable to the naked eye or with the aid of the microscope.

**Histology** is the study of the minute anatomy of the tissues and fluids of the body with the microscope.

**Pathogenesis** is the study of the origin and development of pathological processes.

*Lesions* are appreciable anatomical changes.

**Etiology** is that subdivision of general pathology which treats of the causes of disease. The knowledge of the cause of any morbid action is of value in the prevention, management and removal of disease.

The Causes of disease may be divided into *internal, external, ordinary, specific, primary, secondary, predisposing and exciting*.

Examples of *internal or intrinsic causes* are those having their origin in the mind, such as prolonged mental application, intense or long-continued emotional excitement, long-continued mental depression and the possession of and concentration upon a predominant idea. Other examples are the accumulation of certain products in the blood, such as urea, uric or lactic acid.

*External or extrinsic causes* are such as infectious miasms, viruses, poisons, wounds and injuries.

An *ordinary cause* is one to which all are more or less exposed; to wit, atmospherical changes.

*Specific or special causes* are those producing a distinct and specific disease, such as the special cause of typhoid fever, yellow fever, smallpox and cholera.

A *contagious disease* is one due to a special cause, whose causative agent is a specific poison that, introduced into the body of another, will give rise to the same disease. An *infectious disease* is also due to a special cause that under certain conditions is capable of unlimited increase or multiplication. An infectious disease may or may not be contagious.

An example of a *primary cause* is any external traumatic cause.

A *secondary cause* is well seen in the secondary pericarditis resulting from an accumulation of urea in the blood. The retention of the urea in the blood being due to a diseased kidney.

A *predisposition* to disease is a special liability or susceptibility to its occurrence, and may be either *inherited* or *acquired*.

*Inherited or constitutional predisposition* to certain diseases is also termed *Diathesis*; an example is in the offspring of phthisical parents, who are said to be of a *phthisical diathesis*.

Acquired predisposition is such as arises from—

- I. *Habits*, to wit: Strain upon the nervous system resulting in nervous diseases.
- II. *Age*, to wit: Children are very liable to catarrhal disorders.  
Young adults, to fevers and perverted sexual disorders.  
Middle age, to heart, kidney and digestive disorders and cancer.  
Old age, to degeneration of the heart and vessels.
- III. *Occupation*, to wit: Miners, weavers and cutlers, lung diseases.
- IV. *Sex*, to wit: Women, emotional nervous diseases.  
Men, as more exposed, rheumatism and pneumonia.
- V. *Race*, to wit: Negro, phthisis and scrofula; exempt from malaria.

*Exciting causes* are those giving rise to morbid conditions in those already predisposed to certain diseases, but lacking the action which determines their occurrence; to wit: Persons predisposed to acute rheumatism, on being exposed to certain atmospheric changes have an attack; fear has produced chorea; anger has caused jaundice; worry has produced cardiac troubles.

The **Clinical History** of disease includes all the symptoms and signs which may occur from the *period of incubation* until its final termination.

**Symptoms and Signs** are such alterations in the healthy functions as give evidence of the existence of a diseased condition or perverted function, and may be either *objective* or *subjective*. *Objective*, when evident to the senses of the observer, such as redness or swelling. *Subjective*, when felt by the patient, such as pain or numbness.

The **Period of Incubation** is that interval between the entrance of the poison into the system and its manifestation, and seldom presents recognizable symptoms.

The **Prodromes** are the earliest recognizable symptoms; as the rigors or chills during the invasion of fever, and the various aura preceding an epileptic fit.

An *acute disease* is one in which the invasion is sudden and rapid, and as a rule severe; when the symptoms develop less rapidly and

are less intense the disease is said to be *sub-acute*; when gradual or slow in development, duration and intensity the disease is said to be *chronic*. It must be borne in mind, however, that there may be disturbed action in every intermediate degree between these extremes.

**Pathognomonic** is the term applied to such symptoms as belong to one particular disease, and are therefore characteristic of it, to wit: the rusty sputum of pneumonia.

**Physical signs** are, strictly speaking, *objective* symptoms.

**The Termination** of a diseased action may occur in one of three ways, to wit: *Cure*, *Secondary Processes*, or in *Death*.

*Cure* may occur by—

- I. *Lysis*, or slow return to health.
- II. *Crisis*, abrupt termination, usually with a critical discharge.
- III. *Metastasis*, or changing from one location to another.

*Secondary processes* is when the diseased action is substituted by a new morbid process, to wit: Rheumatism followed by endocarditis; apoplexy by cerebral softening.

By *Death* is meant a complete cessation of tissue change occurring by

- I. *Asthenia*, or an ever increasing debility, to wit: phthisis, cancer, Bright's disease.
- II. *Anæmia*, or insufficient quantity or quality of blood.
- III. *Apnæa*, or non-aeration of blood, to wit: acute lung diseases, or croup.
- IV. *Coma*, death beginning at the brain, to wit: uræmia, narcotic poisoning, cerebral hemorrhage.

**Diagnosis** of disease, or the discrimination of diseases, implies a complete, exact and comprehensive knowledge of the case under consideration, as regards the origin, seat, extent and nature of all its morbid conditions.

*A direct diagnosis* is made when the morbid condition is revealed by a combination of clinical phenomena, or some one or more pathognomonic symptoms.

*A differential diagnosis* is the result when the diseases resembling each other are called to mind and eliminated from each other.

*A diagnosis by exclusion* is by proving the absence of all diseases which might give rise to the symptoms observed, except one, the presence of which is not actually indicated by any positive symptoms.

**Prognosis** of disease is the ability or knowledge to foretell the

most probable result of the condition present, and involves an amount of tact or knowledge only acquired by prolonged clinical experience.

**Treatment.** The ultimate and most important object of the study of medicine, from a practical point of view, is to learn how to cure, relieve, or prevent disease, and it must be borne in mind that this does not consist solely in the administration of drugs, but requires strict and faithful attention to diet and hygiene.

When the object is to prevent disease, such as smallpox by vaccination, it is called *Prophylactic or Preventive* treatment.

When disease is to be broken up, although already begun, such as aborting the chill of malaria, it is called the *Abortive* treatment.

When the disease is allowed to run its natural course without attempting its removal, but being constantly on the alert for obstacles to its successful issue, such as the generally adopted plan of treating continued fevers, it is called *Expectant* treatment.

When the disease is incurable, and removal of marked suffering is the cause, it is called *Palliative* treatment.

When marked weakness and prostration are to be overcome, it is called *Restorative* treatment.

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## FEVERS.

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**Fever** is a condition in which there are present the phenomena of *rise of temperature, quickened circulation, marked tissue change and disordered secretion.*

The *primary cause* of the fever phenomena is a disorder of the sympathetic nervous system giving rise to disturbances of the vaso-motor filaments.

*Rise of temperature* is the preëminent feature of all fevers, and can only be positively determined by the use of the clinical thermometer. The term *feverishness* is used when the temperature ranges from  $99^{\circ}$  to  $100^{\circ}$  Fahr.; *slight fever* if  $100^{\circ}$  or  $101^{\circ}$ ; *moderate*,  $102^{\circ}$  or  $103^{\circ}$ ; *high* if  $104^{\circ}$  or  $105^{\circ}$ ; and *intense* if it exceed the latter.

*Quickened circulation* is the rule in fevers, the frequency usually maintaining a fair ratio with the increase of the temperature. A rise of one degree Fahr. is usually attended with an increase of eight to ten beats of the pulse per minute.

The following table gives a fair comparison between temperature and pulse:—

A temperature of 98° F.	corresponds to a pulse of 60
" " 99° F.	" " " 70
" " 100° F.	" " " 80
" " 101° F.	" " " 90
" " 102° F.	" " " 100
" " 103° F.	" " " 110
" " 104° F.	" " " 120
" " 105° F.	" " " 130
" " 106° F.	" " " 140

*The tissue waste* is marked in proportion to the severity and duration of the febrile phenomena, being slight or nil in febricula, and excessive in typhoid fever.

*The disordered secretions* are manifested by the deficiency in the salivary, gastric, intestinal and nephritic secretions, the tongue being furred, the mouth clammy, and there occurring anorexia, thirst, constipation, and scanty, high-colored, acid urine.

An **Idiopathic** or **Essential** fever is one in which no local affection causes the fever phenomena, although lesions may arise during its progress.

A **Symptomatic** or **Secondary** fever is one dependent upon an acute inflammation.

### GENERAL TREATMENT OF FEVERS.

1. Reduce the temperature. The cold bath or cold pack will do this most decidedly, but entails much labor and is not altogether free from danger, and so its use is advised only in severe cases. Cool sponging is of decided advantage. *Quinina*, in gr. xx doses repeated, is usually reliable. *Antipyrine*, gr. xx repeated and *antifebrin* gr. x-xv repeated, are also recommended.

2. Lessen the circulation. If the pulse be full, strong and rapid, use *aconitum*. If the circulation be weak, *stimulants* with *digitalis* or *caffeina*, are indicated.

3. Attend to the secretions. Remove the waste of the tissues by diuretics, diaphoretics, and, if particularly indicated, laxatives. It is better for every fever that the skin should be moist, than that it should be harsh and dry. It is better that the urine should be abundant, than that it should be scanty and thick with tissue waste. Watch the

stools that you may judge whether the food, be it solid or liquid, is being digested. The free use of water is beneficial in promoting the various secretions.

4. Nourish the patient. "Don't starve a fever." Administer milk, beef-tea, and other light nutritious food, in small quantities, but at frequent intervals.

5. Watch the nursing. Much of the success in the management of fever patients can be attributed to good sensible nursing. Through it are secured the five important essentials of every sick room; to wit: cleanliness, cheerfulness, regularity, ventilation and light.

### CONTINUED FEVERS.

All continued fevers are characterized by a steady progress of the febrile movement, without either a too decided rise or fall in the temperature to modify the impression of a continuous action.

#### SIMPLE CONTINUED FEVER.

**Synonyms.** Irritative fever; febricula; ephemeral fever; synocha.

**Definition.** A continued fever, of short duration, mild in character, not the result of a specific poison, rarely fatal, but when death does occur, presenting no characteristic lesion.

**Causes.** Fatigue, mental and physical; exposure to the sun, great heat or cold; excesses in eating and drinking; excitement and violent emotion. Most common in childhood. It is not a miasmatic fever, neither is it contagious.

**Symptoms.** Onset sudden with an abrupt feeling of *lassitude*, followed by a decided *chill* or *chilliness*, a sudden and rapid *rise of temperature*, quick *tense pulse*, *headache*, *dry skin*, *great thirst*, *coated tongue*, *costive bowels*, and *scanty high-colored urine*. Cases due to errors in diet are accompanied by *nausea* and *vomiting*. Attacks occurring during childhood, due to excitement, fright or the emotions, may be associated with *convulsions*. The *temperature* may within an hour or two reach  $103^{\circ}$  F., or more, when slight *delirium* may occur. The affection has no constant or characteristic eruption.

**Duration.** From twenty-four hours to six or seven days.

**Termination.** Usually within a few hours, to a day or two, the temperature rapidly falls to the norm, an instance of *crisis*; or it may continue for several days gradually falling to the norm (*lysis*). *Herpes*

about the lips and nostrils are often observed at the close of an attack. Convalescence is rapid.

**Diagnosis.** Unless the fever can be attributed to some one of the causes that give rise to it, a doubt as to its character may exist for the first twenty-four hours, after which time it can hardly be mistaken for any other disease.

The following is a familiar instance of this affection. A child, apparently in the best of health, is at play, or, may be at school, suddenly complains of nausea and may vomit, the skin becoming hot, dry and flushed or soon covered with an erythematous rash, the pulse is quick and tense, there is headache, pains in the limbs, and great fretfulness or nervousness. The axillary temperature may reach  $102^{\circ}$ - $104^{\circ}$  F. The whole aspect is most alarming, when a laxative is administered, the surface sponged with a tepid lotion, sleep follows during which there may be free perspiration, and the following day the child is and continues perfectly well.

**Prognosis.** Recovery, without sequelæ, the rule.

**Treatment.** Very little medicine. Rest in bed. A full dose of *hydrargyri chloridum mite*, or an enema, sponging the surface with cold or tepid water, and the administration of saline diaphoretics and diuretics. If there is great arterial excitement *aconitum* may be added. Light liquid diet is most agreeable. Cases in which the nervous symptoms are prominent do well on Fothergill's "fever mixture of the future," to wit :—

R.	Acid. hydrobrom., . . . . .	fʒ ss-j
	Syr. simplicis, . . . . .	fʒ ss-j
	Aquæ, . . . . .	fʒ ij-iij.

M.

Sig.—Every four hours.

*Quininc sulphur* in tonic doses during convalescence.

### CATARRHAL FEVER.

**Synonyms.** Influenza; epidemic catarrhal fever; contagious catarrh.

**Definition.** A continued fever, occurring generally as an epidemic; due to a specific cause; characterized by a catarrhal inflammation of the respiratory organs, and sometimes of the digestive; always accompanied by nervous phenomena and a debility out of proportion to the intensity of the fever and the catarrhal processes. During the prevalence of an epidemic animals suffer more than man.

**Causes.** A specific *vegetable germ*, uninfluenced by soil, climate

or atmospheric changes. It is not contagious. One attack does not give immunity from another attack, but rather predisposes to it.

**Symptoms.** The clinical history of this disease presents the greatest variations as regards intensity, from the most trifling indisposition in one, to an illness of the gravest kind, terminating in death, in another.

The onset is sudden, with a *chill* followed by *fever*, the temperature reaching  $101^{\circ}$  to  $103^{\circ}$ , a *quick, compressible pulse*, and severe *shooting pains* in the eyes, frontal sinuses, joints and muscles. The chill and fever are rapidly followed by *chilliness along the spine, pain in the throat, hoarseness, deafness, coryza, sneezing, injected, watery eye*, and a dry, irritative, *laryngeal cough*, sometimes becoming *bronchial*. The *tongue* is furred, there is *anorexia, epigastric distress, nausea, vomiting*, and oftentimes *diarrhœa*. In some epidemics the digestive symptoms are the most prominent, when *dysentery* may occur.

The above symptoms are always associated with decided *weakness* and *debility* altogether out of proportion to the intensity of the fever and the catarrhal phenomena. Delirium is rare, but marked *hebetude* and *cutaneous hyperesthesia* are common.

**Duration.** Four to seven days, with protracted convalescence. Relapses frequently occur.

**Complications.** Lobar or catarrhal pneumonia frequently occur, which adds to the gravity of the attack. The *cough* may outlast the disease several weeks.

**Diagnosis.** Isolated cases may be mistaken for a "bad cold." But when epidemic, the sudden onset, marked general catarrh and decided prostration should prevent error.

**Prognosis.** Recovery is the rule when it occurs in the healthy and vigorous. *Grave* when the very young, very old, or those suffering from organic disease, such as Bright's disease, fatty heart, or emphysema, are attacked.

**Treatment.** No specific. *Support* the system and treat indications. All measures, of whatever kind, that tend to depress the general nervous system, or the functional activity of the respiration, and especially the heart-power, are to be avoided. The *catarrh*, *pains* and *cough* are at least ameliorated by the following:—

R. Pulvis ipecacuanhæ et opii, . . . . . gr. v.  
Potassii nitrat., . . . . . gr. v.

Every three hours.

Or—

R. Quininæ sulph., . . . . . grs. ij-iv  
 Morphinæ sulph., . . . . . gr.  $\frac{1}{2}$   
 Aquæ lauro-cerasi, . . . . . 3j.

M.

SIG.—Every four hours.

The frequent inhalation of *tinctura benzoin comp.*, ss-j, in *aqua bul.*, Oj, relieves the naso-pharyngeal and bronchial catarrh.

If the bronchial symptoms become troublesome, use—

R. Ammonii muriat., . . . . . grs. x  
 Spts. frumenti, . . . . . f $\frac{1}{3}$  ss  
 Mist. glycyrrh. comp., . . . . . 3 iss.

M.

p. r. n.

Should *Pneumonia* occur, treat as an ordinary case, but *never* depress.

During convalescence administer *strychninæ sulph.*, gr.  $\frac{1}{4}$ , four times daily.

## TYPHOID FEVER.

**Synonyms.** Enteric fever; gastric fever; nervous fever; enteromesenteric fever; abdominal typhus; autumnal fever.

**Definition.** An acute, self-limited, *febrile* affection, due to a *special poison*; characterized by insidious prodromes; epistaxis; dull headache followed by stupor and delirium; red tongue, becoming dry, brown and cracked; abdominal tenderness, early diarrhœa and tympany; a peculiar eruption upon the abdomen; rapid prostration and slow convalescence; a *constant lesion* of Peyer's patches, the mesenteric glands and of the spleen.

**Causes.** Predisposing and exciting.

The chief predisposing causes are *Age*, to wit, young adults, between eighteen and twenty-five years; rare after forty years. I have seen well-marked cases with typical symptoms at eighteen months and at five years of age; and *Season*, to wit, a dry and hot autumn.

The exciting cause is a *special typhoid germ*, the *bacillus typhosus*.

The poison usually results from the *decomposition* of the *typhoid stools and the sputum*, although it has been claimed that the disorder may be generated under certain undetermined circumstances, *de novo*, from ordinary filth and decomposition.

The atmosphere is never impregnated with the fever germ. The poison gains its entrance into the system by means of infected water,

milk, ice, meat or other food. The germ is easily destroyed by thorough disinfection of the stools and sputum with heat, mercuric bichloride or acidum carbolicum, but it is to be borne in mind that *extreme cold will not destroy the typhoid germ.*

**Pathological Anatomy.** The specific anatomical lesions of typhoid fever are invariably present, and are so characteristic that an examination of the body after death will in any case make known the nature of the disease, even had the symptoms been unknown. These lesions consist in changes in the *Peyerian patches* and *solitary glands*, which may be divided into well-defined stages, as follows:—

*First Stage.* Swelling from infiltration and excessive proliferation of their cellular elements; the surrounding mucous membrane is also infiltrated with cells. The Peyer's patches are thickened, hardened and elevated above the mucous membrane. The number of patches and glands involved is from three or four up to nearly the entire number. The above changes have been noted as early as the second day.

*Second Stage.* Softening, sloughing and ulceration of the solitary and agminate glands constitutes this stage. Either of the processes going on in different glands at the same time. Not all the patches necessarily slough; in a certain number of them the morbid changes are arrested before softening. This stage constitutes the anatomical change of the second and third week.

*Fourth Stage.* Cicatrization, or in rare cases perforation. The ulcer gradually diminishes in size, the surface becoming covered with a delicate layer of granulations, which is soon transformed into connective tissue and covered with epithelium, the resulting scar being slightly depressed. The gland-structure is never regenerated.

The Mesenteric glands become infiltrated, enlarged and softened, but seldom ulcerate.

The Spleen also enlarges and softens. There is besides, *parenchymatous degeneration* or *granular changes* in all the tissues of the body.

**Symptoms.** *Stage of Prodromes.*—The onset is insidious, with a feeling of *general malaise*, vertigo, headache, disordered digestion, disturbed sleep, *epistaxis*, depression, and muscular weakness, followed by a *chill* or *chilliness*, the patient being unable to designate the day when the symptoms began. In rare instances the disease begins abruptly with a chill, followed by high fever; this is particularly the case in malarial districts.

*First Week*, dates from onset of the fever, when are present increasing temperature, frequent pulse, coated tongue, nausea, diarrhœa, headache, and upon the seventh day a few reddish spots resembling flea bites appear upon the abdomen, chest or back.

*Second Week*, the foregoing symptoms are exaggerated; fever continuous, frequent and compressible pulse, tympanitic, tender abdomen, gurgling in the right iliac fossæ, nocturnal delirium, severe and constant headache, often stupor, a short cough with distinct bronchial râles on auscultation, irregular muscular contractions (*subsultus tendinum*), sordes upon the teeth and lips, the diarrhœa continuing. During this stage deafness develops, often increasing until complete, continuing into convalescence. Disturbances of vision are frequent in pronounced cases.

*Third Week*. Fever changes from continuous to remittent; the evening exacerbations continue as high as the preceding week, and all the symptoms remain about the same until near the end of the week, when a marked amelioration begins.

*Fourth Week*. The fever decidedly remits; almost normal in morning, the pulse becoming less frequent and more full, the tongue gradually becoming clean, the abdomen lessens in size, the diarrhœa ceases, the patient passing into a slow convalescence, greatly emaciated, which condition may continue for several weeks.

**Analysis of Symptoms.** *The temperature record of typhoid fever is a characteristic one.* The fever on the morning of the first day may be stated at  $98.5^{\circ}$  F., evening  $100.5^{\circ}$ ; second morning  $99.5^{\circ}$ , evening  $101.5^{\circ}$ ; third morning  $100.5^{\circ}$ , evening  $102.5^{\circ}$ ; fourth morning  $101.5^{\circ}$ , evening  $103.5^{\circ}$ ; fifth evening  $104.5^{\circ}$ . From that time until end of the second week, the evening temperature ranges between  $103^{\circ}$  and  $105^{\circ}$ , the morning temperature being a degree or more lower.

*Diarrhœa* is the principal intestinal symptom; if absent, the lesion is slight. The stools are at first dark, but early in the second week they become fluid, offensive, *ochre-yellow* in color, resembling "pea soup," and may be streaked with blood. They number from three to fifteen in the twenty-four hours.

*Constipation* occurs more frequently than is supposed. I have seen fifty cases with constipation within the past five years.

*Eruption* is almost constant. Consists of from five to twenty small, rose-colored spots on the abdomen, chest or back, sometimes on the

limbs, appearing in crops, lasting about five days, disappearing on pressure and at death. Returning with relapses. Eruption day from the seventh to the ninth.

Rarely spots of a delicate blue tint—the “taches bleuâtres” of French authors—are observed.

*Nervous symptoms* are, pronounced headache, early and severe, dullness of intellect soon following, passing into drowsiness and stupor, with great prostration. Deafness pronounced. Sight impaired, in grave cases double vision. Delirium low and muttering, generally pleasant in character; always present in marked cases. Coma vigil is a grave symptom, the patient lying perfectly quiet with eyes open, taking no heed to his surroundings.

*Muscular symptoms* are developed late in the second or early in the third week, and consist of irregular contractions or *subsultus tendinum*, and are the result of great debility. The reverse of muscular contractions, to wit, perfectly motionless in bed, attempting no muscular effort of any kind, is a grave sign.

*Convalescence* shows great debility, great anaemia and great nervousness, often very protracted. It is during convalescence that great irritability of the heart, profuse night sweats and insomnia occur, and in woman loss of the hair.

**Complications.** *Intestinal hemorrhage* is the most frequent and at times the most critical of any of the complications of typhoid fever. The hemorrhage may occur any time between the fourteenth and twentieth day; a sudden decline of the temperature to the norm or below frequently precedes the passage of blood by stool. The hemorrhage is due to the erosion of a vessel during the ulcerative action.

*Perforation* makes the case almost hopeless. *Peritonitis* without perforation adds to the gravity, but not necessarily fatal. *Lobar pneumonia*, *hypostatic congestion* and *bronchitis* are frequent occurrences. *Albuminuria* may occur, as may *phlegmasia dolens*.

**Relapses are common.** The symptoms all return abruptly; the duration is half the time of the original attack; occur at the end of the fourth or beginning of the fifth week. Not so fatal as generally supposed.

*Abortive typhoid fever* are cases of mild character, having many of the typical symptoms, running its course in about two weeks. The so-called *walking cases* are often of this character.

**Diagnosis.** An error that is constantly being made is that of confounding typhoid fever with the typhoid (depressing) symptoms or condition developing during the course of many acute diseases. The absence of the characteristic *diarrhœa*, the peculiar *eruption*, and the typical *temperature record*, should prevent the error.

*Enteritis* has intestinal disorders alone.

*Peritonitis*, abdominal symptoms only, with constipation.

*Acute miliary tuberculosis* often mistaken for typhoid fever, an error difficult to prevent at times.

*Meningitis* lacks the intestinal symptoms and fever record.

The so-called *typho-malarial* or *malaria-typoid* fever has many symptoms in common, but lacks the diarrhœa, eruption and temperature record.

**Prognosis.** A positive prognosis cannot be made. Favorable indications are constipation, slight diarrhœa, low temperature and moderate delirium. Unfavorable symptoms are obstinate and severe diarrhœa, early high temperature, marked nervous symptoms with coma vigil or stupor, albuminuria and repeated intestinal hemorrhages.

The prognosis is always more favorable in winter than in summer.

The *mortality* in typhoid fever in private practice is about one death in twenty; in hospital practice it varies from one death in five to ten cases.

**Treatment.** No specific. Chiefly symptomatic and expectant, with intelligent nursing, pure air, quiet sick chamber, and *disinfecting the urine and the stools*, with a nutritious liquid diet at intervals of every two or three hours. A word of caution, however, as to the quantity of food administered. The amount should be small, as the digestive capacity of the patient is greatly lessened by the febrile phenomena. Much harm results in typhoid fever from stuffing the patient.

The following remedies have advocates, claiming that they modify the course of the disease; to wit: *Hydrargyrum*, *iodum*, *acidum carbolicum*, *mineral acids*, *argentum nitras*, and *ergota*.

A mild case of the disease will do well with *acidum hydrochloricum dilutum*,  $\text{m}_x\text{-xx}$ , well diluted, every four hours, alternated with *quininæ sulphas*, gr. ij.

Cases with high temperature and costive bowels are sometimes wonderfully benefited by the following:—

R. Hydrargyri chlor. mite, . . . . . gr.  $\frac{1}{4}$   
 Pulv. ipecacuanhae, . . . . . gr.  $\frac{1}{2}$   
 Pulv. opii, . . . . . gr.  $\frac{1}{6}$ .

Repeated every three or four hours, and *quininæ sulphas*, gr. ij, every four hours.

The present so-called "specific treatment" of this disease consists in the administration every second evening, until four doses are taken, of *hydrargyri chlor. mite*, gr. viij-x, which seemingly lessens the frequency of the stools in the later stages of the attack, although slightly increasing them at the time. Also administering from the beginning of the attack—

R. Tinct. iodi., . . . . . 3ij  
 Acid. carbol. liq., . . . . . 3j. M

SIG.—One, two or three drops in ice water, every two or three hours, after food.

To reduce the temperature, use either the cold bath, cold pack, and cold sponging, with *quininæ sulph.*, gr. xv-xx, repeated within an hour, or *antipyrine*, gr. xx, repeated *pro re nata*.

*Diarrhœa* should not be checked unless it exceeds *three stools* in twenty-four hours, when may be used—

R. Bismuth subnit., . . . . . gr. xx  
 Acid. carbol., . . . . . gtt. j  
 Tinct. opii deodorat., . . . . . gtt. x-xv  
 Mucil. acaciæ, . . . . . 3j  
 Aquæ, . . . . . 3 iiij. M.

SIG.—Every three or four hours.

Or—

R. Cupri sulph., . . . . . gr.  $\frac{1}{8}$   
 Extracti opii, . . . . . gr.  $\frac{1}{4}$ . M.

SIG.—In pill, every four hours.

For *Tympanites*; cold compresses or turpentine stupes to the abdomen, or R. *ol. terebinthinæ*, gtt. x, *morphinæ sulph.*, gr.  $\frac{1}{10}$ , in emulsion, every third hour, or *tinct. nucis vomicis*, gtt. x, *p. r. n.*

Tympany with constipation is relieved by the use of *olei terebinthinæ*, gtt. x, *olei ricini*, gtt. xv, in emulsion every three or four hours.

For *Thirst*; cooling drinks, in moderation, or pellets of ice slowly dissolved in the mouth.

*Headache*; cold to the head, mustard to the neck, and foot baths; if these fail to relieve, *morphina* or *atropina* hypodermically.

*Delirium*; if from debility, increase the stimulants; other causes, use *morphina*.

*Restlessness and coma vigil; chloral alone or with potassii bromidum, or morphina.*

*Debility; food every two or three hours; do not permit sleep to interfere with nourishment. Stimulants are indicated early; the best guide being the heart's action; an average amount would be ʒvj spts. vini gallici, per diem, or chloroformi, ʒij-v every hour or two, well diluted, or moschus, gr. x, repeated p. r. n.*

*The bladder should be examined at each visit.*

*Intestinal hemorrhage; at once morphina, gr. ¼, hypodermically, and ext. ergotæ ftd., ʒj, repeated p. r. n., or Monsell's solution, gtt. ij-iv, every two hours, or acidum tannicum, gr. ij-v, with pulv. opii et ipecacuanhæ, gr. iij every hour.*

*Perforation and peritonitis; at once morphina sulphas, gr. ½, hypodermically, followed with extractum opii, gr. j every hour, hot application to the abdomen and bold stimulation.*

## TYPHUS FEVER.

**Synonyms.** Contagious fever; ship fever; jail fever.

**Definition.** An acute febrile, *epidemic* disease; highly *contagious*, and characterized by sudden invasion, profound depression of the vital powers, sickening odor, and a peculiar petechial eruption; favorable cases terminating by *crisis* about the fourteenth day. No lesion.

**Cause.** A special infecting germ, the character of which is unknown, but which is influenced by filth and overcrowding. Rarely seen in the United States.

**Pathology.** No constant lesion. Blood dark and thin, with lessened fibrin; tissues dark, soft and flabby.

**Symptoms.** Begins abruptly; *chill* followed by violent *fever*; temperature within a few days reaching 104° to 105° F.; a frequent, bounding *pulse*, soon becoming compressible; severe *headache*, followed by violent *delirium*; from the *fifth* to the *seventh* day, a coarse, red, measly *eruption*, with a mottling of the skin all over the body, except the face, not disappearing on pressure; *constipation* the rule. End of the second week, the temperature suddenly declines and the case passes into a *rapid convalescence*.

**Complications.** Pneumonia and swollen parotid glands are common.

**Diagnosis.** From *typhoid fever*, the age, season, onset of the disease, character of the eruption, and the intestinal symptoms.

*Measles* begin milder, with coryza and cough, and seldom have such pronounced nervous phenomena, but there occurs an early eruption appearing on the face.

**Prognosis.** *Unfavorable indications*; high temperature, frequent pulse, early stupor, presentiment of death. *Favorable*; youth, moderate temperature and pulse, and mild nervous phenomena.

**Treatment.** Symptomatic. As *typhus fever* is distinctly contagious, *isolation* is imperative, with immediate removal and *disinfection* of the patient's excreta.

All cases are benefited by small doses of the *mineral acids* alternating with *quininae sulphas*.

For *high temperature*, cold pack, cold bath, cold sponging, full doses of *quinina* or *antipyrine*.

For the *headache* and *delirium*, cold to the head, in the young and strong, a few leeches to the temple, and *chloral*, with or without the *bromides*.

For *constipation*, mild laxatives.

*Debility*; *alcohol* early and in full doses, *spiritus chloroformi* in drachm doses, whenever danger of collapse.

## CEREBRO-SPINAL FEVER.

**Synonyms.** Epidemic cerebro-spinal meningitis; epidemic cerebro spinal fever; spotted fever; cerebro-spinal typhus.

**Definition.** A malignant *epidemic fever*, characterized by headache, vomiting, painful contractions of the muscles of the back of the neck, retraction of the head, hyperæsthesia, disorders of the special senses, delirium, stupor, coma, and frequently an eruption of petechia or purpuric spots—a subcutaneous extravasation of blood. Lesions of cerebral and spinal membranes are found at the *post-mortem*.

**Cause.** A special micro-organism, of oval shape, occurring mostly in pairs and faintly tremulous, resembling those found in pneumonia and erysipelas, though hardly identical. Bad hygiene seems to favor the development of this affection, but can hardly be considered its cause.

The disease seems to have a predilection for the young. Occurs most frequently in the winter months. *Not contagious*.

**Pathological Anatomy.** The extent of lesion present in a

given case depends upon the duration of the illness. In cases rapidly fatal, it is probable that the subject is overwhelmed by the poison ere the characteristic anatomical changes have time to develop.

The changes in this disease are twofold, to wit: those due to the direct action of the infecting poison upon the blood, producing the group of symptoms constituting the fever; and those giving rise to the local inflammation, viz: *Hyperæmia* of the membranes of the brain and spinal cord, followed by an *exudation of lymph* and an *effusion of serum*, resulting in pressure on the brain and cord. The inflammatory changes are more marked in the membranes at the base of the brain than elsewhere.

**Symptoms.** Divided, according to the severity of the lesion, into three groups, to wit: the *common form*, the *fulminant* and the *abortive*.

*The Common Form* begins abruptly with a *chill*, excruciating *headache*, persistent *nausea*, *vomiting*, *vertigo*, and an overwhelming sense of *weakness*. Within a few hours the muscles of the back of the neck become *rigid* and *retracted*, with decided *pain* upon moving the head; this rigidity and retraction soon extends to the back, when *opisthotonus* occurs. There is great restlessness, and the surface of the body becomes highly sensitive (*hyperesthesia*). Cramps in the muscles of the legs and elsewhere, and spasmodic twitchings of the lips and eyelids come and go, and finally *convulsions* or *delirium* occur. Intolerance of light, and in some cases *amaurosis*, more or less *deafness*, loss of sense of *smell* and *taste* soon following. The *temperature* and *pulse* records are irregular. From the *first day* to the *fifth* an *eruption* of *petechiæ* or *purpura* occurs in the majority of cases. The disease reaches its height in from three to eight days, and passes into *stupor* and *coma*, or ameliorates and passes into a protracted convalescence.

*The Fulminant Form.* Severe *chill*, *depression*, and in a few hours *collapse*. The patient is overcome by the poison and never reacts.

*The Abortive Form* consists of one or more pronounced characteristic symptoms during the course of an epidemic.

**Sequelæ.** Result from thickening of either the cerebral or spinal membranes; persistent *headache*, *blindness* or *deafness*, partial or complete; *epilepsy*, or different forms of *spinal palsies*.

**Complications.** Pneumonia; typhoid fever; pleuritis; intestinal catarrh, in infants.

**Diagnosis.** *Typhoid fever* begins slowly, has a characteristic temperature record, without so intense headache, muscular rigidity, vomiting, early delirium, ending in coma.

*Typhus fever* has higher fever, is of longer duration, and has a peculiar measles eruption, is not attended with muscular rigidity and retraction, hyperesthesia, nor disorders of the special senses.

*Tubercular meningitis* is not epidemic, has no characteristic eruption; is preceded by long prodromes, and runs a tedious course.

*A congestive chill* resembles the fulminant cases in suddenness of depression, but the latter has not the history of the former.

*Inflammation of the meninges of the cord* is due to exposure to cold, or syphilis, and is not attended with cerebral symptoms or an eruption.

**Prognosis.** Varies according to epidemic; from twenty to fifty, and even seventy-five per cent. die.

**Treatment.** There is no abortive plan of treatment for cerebro-spinal fever, nor can the antiphlogistic treatment of the inflammatory symptoms be advised. Like the infectious diseases in general, sustaining measures are indicated in all but the most sthenic cases.

Nutritious and easily assimilated food, such as milk, eggs, meat-juice and broths, should be given at regular intervals night and day. If food cannot be taken by the mouth, nutritious enemata should be substituted.

The drug that holds the highest place in the treatment of this disease is *opium*.

The hypodermic use of *morphina*, gr.  $\frac{1}{4}$  to  $\frac{1}{2}$  every two or three hours; or *extractum opii*, gr. j every hour until stage of effusion in adults, when *quinina* in tonic doses, and *potassii iodidum* are indicated. Prof. DaCosta alternates *potassii bromidum* with *opium*, especially in children.

Locally, warmth to the surface, with hot sponging along the spinal column and to the nape of the neck. The cautious use of cold compresses to the head for headache may be useful in some cases.

For sequelae, *potassii iodidum*, a course of *hydrargyrum*, *oleum morrhuae*, and flying blisters along the spinal column.

## RELAPSING FEVER.

**Synonyms.** Famine fever; bilious typhoid fever.

**Definition.** An epidemic, *contagious*, febrile disease, self limited; characterized by a febrile paroxysm, succeeded by an entire intermission, which is in turn followed by a *relapse* similar to the first seizure. No specific lesion.

**Cause.** A specific poison; *contagious*; acquiring the greater activity the more filthy, crowded and unhealthy the population amid which it prevails.

**Pathological Anatomy.** During the febrile paroxysm *only*, blood contains minute cork-screw-shaped organisms or *spiral filaments*—*spirilli*, constantly twisting and rotating.

Liver and spleen greatly swollen.

**Symptoms.** No *prodromes*. Onset abrupt, with fever,  $102^{\circ}$ – $104^{\circ}$ ; frequent, rather *weak pulse*, *headache*, nausea, *vomiting*, and lancinating *pains* in limbs and muscles, marked in the calf of leg; *second day*, feeling of *fullness* and *pressure* in right and left hypochondrium, due to swollen liver and spleen; *jaundice* is frequent; *seventh day* fever ends by *crisis*; *fourteenth day* symptoms return in milder form, continuing about four days, when enters slow convalescence, much emaciated. *No eruption*. Several *relapses* may occur.

**Diagnosis.** *Yellow fever* has many points of resemblance, but has a shorter febrile stage, remission not so complete, vomiting late and characteristic, normal spleen, and the late appearance of yellow color.

*Remittent fever* begins with a decided chill, followed by fever and sweats, and not the progressive rise of temperature till the fifth or seventh day.

**Prognosis.** Recovery the rule, but protracted, and decided emaciation results.

**Treatment.** *Expectant.* Act on secretions; nourish patient and meet urgent symptoms. For fever, antipyretic doses of *quinina* which, however, has no power to prevent the relapses; for pain, hypodermic injections of *morphina*; for nausea and vomiting, *acidum carbolicum* or *cerii oxalas*; during remission, *ferrum* and *quinina* in tonic doses.

## PERIODICAL FEVERS.

These affections are characterized by the distinct periodicity of the phenomena, having intervals during which the patient is wholly or nearly free from fever.

### INTERMITTENT FEVER.

**Synonyms.** Ague; chills and fever; malarial fever; swamp fever.

**Definition.** A *paroxysmal* fever, the phenomena observing a regular succession; characterized by a cold, a hot and a sweating stage, followed by an interval of complete *intermission* or apyrexia, varying in length, according to the variety of the attack.

**Cause.** Malaria. *Bacillus Malaria?*

The period of incubation varies from a few days to weeks, months or even years, an auxiliary condition such as exposure to cold, over-exertion, excesses in eating and drinking, or great excitement often being necessary to give efficiency to the special cause.

Either sex and all ages are susceptible to the poison.

**Pathological Anatomy.** Blood dark, from the formation of pigment (*Melanæmia*). Spleen swollen (*Ague cake*). Liver engorged and swollen.

**Varieties.** *Quotidian* when a daily paroxysm; *tertian* when every other day; *quartan* when it occurs first and fourth days; *octan* when weekly; *duplicated quotidian* when two paroxysms daily; *duplicated tertian*, two every second day; *double tertian*, daily paroxysm, but more severe every second day. *Dumb ague*, or masked ague, presents irregularity of the characteristic phenomena.

**Symptoms.** Each paroxysm has three stages, the *cold*, *hot* and *sweating*.

*Cold stage* begins with *prodromes*, to wit: lassitude, yawning, headache and nausea, followed by a *chill*; the teeth chatter, skin pale, nails and lips blue, the surface rough and pale, the so-called *goose-skin* or *cutis anserina*, nausea and great thirst, while the thermometer in the axilla or mouth shows a decided *rise of temperature*,  $102^{\circ}$  F.- $104^{\circ}$ ; these phenomena continuing from one-half to an hour.

*Hot stage* begins gradually, by the shivering ceasing, the surface becoming *hot* and flushed, the temperature rising to  $106^{\circ}$  F., or more, *pulse full*, *headache*, *nausea*, *intense thirst*, dry, flushed, swollen skin,

scanty urine and other phenomena of *pyrexia*, continuing from one to eight or ten hours.

*Sweating stage* begins gradually, first appearing on the forehead, then spreading over the entire surface; the *fever lessens*, the temperature rapidly falling to  $99^{\circ}$  or  $98^{\circ}$ , pulse less full, headache lessens, and a general feeling of comfort exists, sleep often following; duration of the sweating from one to four hours, when the *intermission* occurs, the patient apparently well, except for a feeling of general debility.

The occurrence of the next paroxysm depends upon the variety of the attack.

The paroxysm may be ushered in by a decided pain in one or more nerves, instead of the cold stage, to wit: "*brow ague*."

**Diagnosis.** No difficulty when the characteristic *chill, fever, and sweats* occur.

*Hectic fever.* Distinguished by its irregularity, and occurring secondary to an organic disease.

#### *Pyæmia* produced by other causes than malaria.

*Nervous chills* show an absence of the temperature rise.

**Prognosis.** Recovery the rule. Without treatment many cases end favorably after several paroxysms; others passing into the *chronic* form or *malarial cachexia*.

**Treatment.** *Cold stage* can be averted and the other stages greatly modified by a hypodermic injection of either *morphinæ sulph.*, gr.  $\frac{1}{8}$ - $\frac{1}{4}$ , or *pilocarpinæ hydrochloras*, gr.  $\frac{1}{8}$ , or *chloroformi spts.*, f 3j, by the stomach. *Hot stage*, cool drinks and cold sponging. *Sweating stage*, when excessive, sponging with *alumen* and hot water.

*Intermission*; at once a brisk purgative, followed by *cinchona* in some form, the most efficient being *quininæ sulph.*, gr. xx-xxiv, in solution or freshly-made pills, in one or two doses, *three to five hours before* the expected paroxysm. Many substitutes are lauded to replace the salts of *cinchona* bark, but without avail.

After the paroxysms are broken up, use *liq. potassii arsenit.*, gtt. v-x, *t. d.*, for a long time, or *tinct. ferri chloridi*, gtt. xx, every four hours, or a combination like the following:—

R.	Ferri reducti,	
	Quininæ sulph., . . . . .	ää . . . . . gr. xlviij
	Acidi arsenio-i, . . . . .	gr. j
	Chloro-quin.	att. xv

Ol. pip. nigr.,  
Fr. pil. No xxiv

SIG.—One pill after meals, continued for one month, at least.

*Relapses* being common, *quinina* should be given on the *second* or *third day, fourth to the sixth, twelfth to the fourteenth, and nineteenth to the twenty-first days.*

### REMITTENT FEVER.

**Synonyms.** Bilious fever; bilious remittent fever; marsh fever; typho-malarial fever?

**Definition.** A *paroxysmal* fever, with exacerbations and *remissions*; characterized by a moderate cold stage (which does not recur with each paroxysm); an intense hot stage, with violent headache and gastric irritability; and an almost imperceptible sweating stage, which is frequently wanting.

**Cause.** Malaria, aided by high temperature.

**Pathological Anatomy.** Blood dark (*Melanæmia*); spleen enlarged, soft, filled with blood, and of an *olive* color; liver congested and swollen, and of a *bronze* hue; the brain hyperæmic and olive-colored; gastro-intestinal canal markedly hyperæmic.

**Symptoms.** *Cold stage*; moderate *chill*, the temperature rising  $1^{\circ}$  to  $2^{\circ}$ , coated, dry tongue, *oppression at the epigastrium*, slight *headache*, and pains throughout the body.

*Hot stage*; persistent *vomiting*, furred tongue, *full pulse*, rising to 100 or 120, flushed face, *injected eye*, violent *headache*, *pains in limbs and loins*, hurried *respiration*, the *temperature* rising to  $104^{\circ}$  F., or  $106^{\circ}$ . The bowels costive, *stools tarry* and offensive, and the *surface* becoming *yellow*. *Delirium* occurs when the temperature is very high.

*Sweating stage*; after six to twenty-four hours, the above symptoms abate, and *slight sweating* occurs; the *pulse*, *headache* and *vomiting* subside, and the *temperature* falls to  $100^{\circ}$  F., or  $99^{\circ}$ .

This is the *remission*.

After some *two to eight or twelve* hours, the symptoms of the *hot stage* return, generally *minus* the *chill*, and this is termed the *exacerbation*, which is in turn again followed by the *remission*.

**Duration.** From seven to fourteen days, the average. Frequently the fever *ceases to remit*, and instead, becomes *continuous*, the symptoms resembling, if they are not identical with, the *typhoid state*, whence the term *typho-malarial fever*, or *malaria-typhoid fever*.

**Sequelæ.** The *malarial cachexia* results when the poison has not been eliminated from the system.

*Persistent headache* and vertigo are the results of the intense meningeal hyperæmia that sometimes occurs.

**Diagnosis.** In *intermittent fever* each paroxysm begins with a chill, while the chill seldom recurs in remittent fever; a distinct *intermission* follows each paroxysm of the intermittent form, while a *remission* occurs in remittent, the thermometer showing that the fever does not wholly disappear; during the *intermission* the patient is apparently well; such is not the case in the remission of remittent fever.

*Typhoid fever* is mistaken for remittent fever, but the absence of the characteristic temperature record, diarrhoea, eruption, tympanites, deafness and severe prostration, should prevent such an error.

**Prognosis.** Uncomplicated cases are favorable.

**Treatment.** *Quininæ sulph.*, gr. xvij–xx per diem, is the remedy. Better administered during the *remission*, if possible. If an irritable stomach prevents its administration by the mouth, use it by the *hypodermic method* or in a *suppository*. During the *hot stage*, cool sponging, cold to the head, and if a tendency to cerebral congestion, dry or wet cups to the nape of the neck and—

R.	Tinct. aconit. rad., . . . . .	gtt. j–ij	
	Liq. potas. citrat., . . . . .	3 ij	
	Liq. ammon. acetat., . . . . .	3 ij.	M.

Every two hours.

*Purgation* during the remission, with—

R.	Hydrarg. chlor. mitis, . . . . .	gr. v	
	Sodii bicarb., . . . . .	gr. x	
	Pulv. aromat., . . . . .	gr. v.	M.

In pulv. p. r. n.

The same precautions are essential after the paroxysms are broken up, to prevent their return on the septenary periods, that were recommended for *intermittent fever*.

## PERNICIOUS FEVER.

**Synonyms.** Congestive fever; malignant *intermittent fever*; malignant *remittent fever*.

**Definition.** A malignant, destructive *malarial fever*, which may

be of the intermittent or remittent form; characterized by *intense congestion* of one or more internal organs, *together with dangerous perversion of the functions of innervation*.

**Cause.** A high degree of malarial poison.

**Varieties.** *Gastro-enteric*; *thoracic*; *cerebral*; *hemorrhagic*; *algid*.

**Symptoms.** Any of these varieties may begin either as in *intermittent* or *remittent fever*; again, the *first paroxysm* is rarely pernicious, but appears as the ordinary malarial attack.

The *gastro-enteric* variety has as distinctive features, *intense nausea* and *vomiting*, *purgings* of thin discharges mixed with blood, *tenesmus*, *burning heat in stomach*, *intense thirst*, *frequent*, *weak pulse*, *face, hands and feet cold*, with *shrunken features*, and *intense depression of all the vital forces*. This condition continues from half an hour to several hours, when either an inter- or remission occurs.

*Thoracic* variety often combined with the one just described. Its characteristic features are due to overwhelming congestion of the lungs, such as *violent dyspnœa*, *gasping* for air, fifty to sixty respirations per minute, *oppressed cough* with slight amount of blood-streaked sputa, *frequent, weak pulse*, *cold surface*, and *terror-stricken features*. Duration same as the above.

*Cerebral* variety, due to intense congestion of the brain; sometimes effusion of serum into the ventricles, or even rupture of small blood vessels. Characterized by *violent delirium*, followed by *stupor* and *coma*, *slow, full pulse*, the surface either *flushed* or *livid*. Cases may either resemble *apoplexy*—*comatose variety*, or *acute meningitis*—*delirious variety*. Duration same as the other forms.

*Hemorrhagic* variety, or the *yellow disease*, as it has been termed, begins as an ordinary inter- or remittent fever, soon followed by signs of *internal congestion*, to wit: *nausea*, *vomiting*, *dyspnœa*, *severe pains over liver and kidney*, continuing for a few hours, when the *surface suddenly turns yellow* and *bloody urine* is voided, after which an inter- or remission and marked abatement occur, to be sooner or later followed by a second paroxysm, which is more severe, with additional signs of *cerebral congestion*. Blood may also escape from other parts than the kidneys.

*Algic* variety is characterized by intense *coldness* of the surface, while the rectal temperature ranges from  $104^{\circ}$  to  $107^{\circ}$  F. The attack begins with a *chill*, which is soon followed by *fever* of variable dura-

tion, when the body becomes *cold*, the axillary temperature falling to  $90^{\circ}$ ,  $88^{\circ}$  or even  $85^{\circ}$  F., a *cold sweat* covers the surface, the tongue is *white, moist and cold*, the *breath* is *icy*, the *voice* *feeble and indistinct*, the *pulse slow, feeble* and often *absent* at the wrist, and with all these symptoms, the patient complains of a sensation of *burning* and *intense thirst*. The *mind is clear*, but the countenance is *death-like*.

**Duration.** Pernicious fever, in any of its forms, may continue from a few hours until one, two or three days. Recovery is rare after a *second*, almost never after a *third*, paroxysm.

**Diagnosis.** *Yellow fever* is most apt to be confounded with the *hemorrhagic variety*, and as they both occur in the same localities, the diagnosis is difficult; the early *yellowness* of the surface, with *haematuria*, and the absence of the *black vomit*, an epidemic prevalence, are the chief points of distinction.

The *cerebral variety* may be mistaken for *cerebral apoplexy, meningitis* and *uræmic convulsions*. Nor is it always an easy matter to differentiate between these conditions.

The *gastro-enteric variety* may be mistaken for the early stage and the *algid variety* for the latter stage of *cholera*, but the epidemic prevalence of the latter should be of material aid in determining the diagnosis.

**Prognosis.** In all varieties the result is unfavorable, unless it can be controlled prior to the *second* paroxysm. Cases in which an *intermission* occurs are better controlled than where a *remission* follows. The mortality is *one in eight* from all plans of treatment.

**Treatment.** The first indication in all varieties is to bring about *reaction*. If the *cold stage*, heat to the surface, with stimulating lotions; if the *hot stage*, cold to the surface and the hypodermic injection of *morphina*, gr.  $\frac{1}{4}$ , at once. After *reaction*, *quininæ sulph.*, not less than gr.  $xl$ , repeated p. r. n.; administer by stomach, rectum, or better still, by hypodermic injection. Dr. Bartholow pronounces the following one of the best formulæ for the hypodermic use of quinina:—

R.	Quininæ disulph., . . . . .	gr. 1
Acid. sulph. dil., . . . . .	m <sub>c</sub>	
Aquaæ font., . . . . .	ʒj	
Acid. carbol. liq., . . . . .	m <sub>v</sub> .	M.

The following formula, known as "Warburg's Tincture," has during the last few years gained considerable reputation in the various forms of malarial fevers:—

R.	Rad. rhei, P. aloe soc. and Rad. angelica officinalis, . . . . .	āā . . . . .	ʒ iv
	Rad. helenii, Crocus Hispan., Sem. foeni-culi, and Cretæ preparat., . . . . .	āā . . . . .	ʒ ij
	Rad. gentian, Rad. zedoar, P. cubeb, G. myrrh, G. camphor, and Boletus Laricis, . . . . .	āā . . . . .	ʒ j
	Confect. democratis,* . . . . .	āā . . . . .	ʒ iv
	Quininæ sulph., . . . . .	āā . . . . .	ʒ lxxxij
	Spt. vini rect., . . . . .	āā . . . . .	Oxx
	Aquaæ puræ, . . . . .	āā . . . . .	Oxij.

Macerate in a water bath twelve hours, express and filter.

Each half ounce contains quininæ sulph., gr. vijss. If the stomach is too irritable to retain the tincture, the tincture may be evaporated to dryness and administered in *capsules*, each containing the equivalent of either one or two drachms.

For the *gastro-enteric* variety, Prof. Da Costa suggests—

R.	Morph. sulph., . . . . .	gr. $\frac{1}{3}$
	Pulv. camph., . . . . .	gr. $\frac{1}{2}$
	Mass. hydrarg., . . . . .	gr. ij
	Pulv. capsici, . . . . .	gr. ss.

M.

In pills every half-hour until the character of the stools change.

For the *thoracic* variety, dry or wet cups and *ammonii carbonas*.

For the *cerebral* variety, venesection, or cups or leeches to the neck, cold to the head, prompt purgation, and acting on the kidneys and skin.

\* Formula of *Confectio democratis* :—

Cinnamon.....	xiv Gm.
Myrrh .....	xj Gm.
White agaric, Spikenard, Ginger, Spanish saffron, Treacle, Mustard seed, Frankincense, and Chian turpentine.....	āā..... x Gm.
Camel's hay, Costus arabicus, Zeodary, Indian leaf, Mace, French lavender, Long pepper, Seeds of harwort, Juice of rape cistus, Strained storax, Opponex, Strained galbanum, Balsam of Gilead, Oil of nutmeg, Russian castor.....	āā..... viij Gm.
Water germunder, Balsam tree fruit, Cubeb, White pepper, Seeds of carrot of Crete, Poley mont, Strained bdellium .....	āā..... viij Gm.
Gentian root, Celtic hard, Leaves of Dittany of Crete, Red rose, Seeds of Macedonium, Parsley, Sweet fennel seed, Seeds of lesser cardamon, Gum arabic, Opium .....	āā..... v Gm.
Sweet flag, Wild valerian, Anise seed, Sagaper- num .....	āā..... iij Gm.
Spigrul, St. John's wort, Juice of acacia, Catechu, Dried bellies of skunk.....	āā..... ijss Gm.
Clarified honey.....	cmxv Gm.

The roots to be finely powdered and the whole mixed thoroughly.

For the *algid* variety *warmth* to the surface, hypodermic use of *morphina* and the free use of *ammonii carbonas* and *alcoholic stimulants*.

For the *hemorrhagic* variety, purgatives, *morphina* hypodermically, and either *acid. sulph. dil.*, *acid. gallic*, *Monsell's solution*, or *terebinthina*, for the hemorrhages.

The following is highly spoken of for hemorrhages:—

R.	Ext. ergotæ fld., . . . . .	$\frac{3}{3}$ ss	
	Acid. sulph. dil., . . . . .	f $\frac{3}{3}$ jss	
	Acid. gallic., . . . . .	$\frac{3}{3}$ j	
	Syr. zingib., . . . . .	f $\frac{3}{3}$ iiij	
	Aquæ, q. s., . . . . . ad	f $\frac{3}{3}$ iiij.	M.

SIG.—Dessertspoonful every 4 hours, well diluted.

After the paroxysms are controlled, a long course of *ferrum*, with *quinina* on the septenary days.

## YELLOW FEVER.

**Synonyms.** Bilious malignant fever; typhus icterode; Mediterranean fever; sailors' fever.

**Definition.** An acute, infectious, paroxysmal disease, of three stages, to wit: the *febrile*, the *remission*, and the *collapse*; characterized by violent fever, yellowness of the surface, and "black or coffee-ground vomit." Tendency fatal; one attack confers immunity from a second.

**Cause.** A specific poison, existing only with a high temperature and destroyed by frost. *Not due to the malarial poison.*

**Pathological Anatomy.** Skin lemon or greenish-yellow color, due to dissolution of the red blood corpuscles; heart softened by granular degeneration; stomach, veins deeply engorged, the mucous membrane softened, and containing more or less "coffee-ground" matter, which consists of blood corpuscles deprived of their haemoglobin, white corpuscles, epithelial cells and débris. Intestines much the same as the stomach; liver, yellow color and a fatty degeneration of the hepatic cells; kidneys, granular degeneration of the epithelium of the tubules.

**Symptoms.** First stage, the *febrile*, beginning either with the prodromata of *malaise*, headache and anorexia, or suddenly with a *chill*, high *fever*, in a few hours reaching  $104^{\circ}$  to  $106^{\circ}$  F., high *pulse*,

90-100 beats, brilliant eye, flushed countenance, coated tongue, irritability of the stomach, and severe neuralgic pains in the head, limbs, epigastrium, back and large joints. The patients are restless, anxious, with a feeling of general prostration. In severe attacks delirium is frequent. *Albumin* in the urine, and a peculiar and characteristic odor is emitted from the patient. Duration of the first stage from thirty-six hours to three or four days.

*Second stage*, the remission, when the temperature declines to 100° or 101° F., and all the distressing symptoms abate or subside and, with some critical evacuation, convalescence occurs, or, more commonly, after from a few hours to one to four days, the

*Third stage*, the stage of collapse, or the period of secondary fever, is ushered in by a return of all the symptoms of the first stage in an exaggerated form, followed by yellowness of the skin, passing to a deep mahogany color, black vomit and hemorrhages from other parts, feeble pulse, cold surface, irregular respiration, and death from exhaustion, the mind remaining clear until the end.

The above symptoms represent a *sthenic* case; other varieties are the *algid*, *hemorrhagic* and *typhus*.

**Duration.** Depends upon the variety; from a few hours to a few days. Rarely continues longer than one week.

**Diagnosis.** *Pernicious fever*, hemorrhagic variety, is apt to be mistaken for yellow fever. Yellow fever is a disease of *one* paroxysm, and *one* remission, epidemic, with albuminuria and black vomit. *Pernicious fever* has more than one paroxysm, not epidemic, rarely black vomit or albumin in urine.

**Prognosis.** One in four perish. Short cases unfavorable, as are the hemorrhagic and *algid* varieties.

**Treatment.** No specific; a "self-limited" disease. The indications are to treat the symptoms and nourish the patient. Good nursing, ventilation, early emesis and purgation, with diaphoretics and diuretics, are apparently beneficial. Large doses of *quinina*, early in the attack, for high temperature; for the irritable stomach, ice slowly dissolved in the mouth and *acidum carbolicum*, gr.  $\frac{1}{4}$  in *aqua menthae pip.*, every two hours, alternated with *liquor calcis* and milk, each an ounce, or—

R. Hydrargyri chlor. mite, . . . . . gr.  $\frac{1}{2}$   
Morphinæ sulph., . . . . . gr.  $\frac{1}{4}$ .

Every two hours until nausea controlled.

For the black vomit and hemorrhages, either *liquor ferri subsulphatis* or *plumbi acetum*. The pains, restlessness or delirium are best controlled by the hypodermic use of *morphina* or *atropina*. Free stimulation from the onset is essential.

## ERUPTIVE FEVERS.

As a group, the eruptive or exanthematous fevers have many features in common. All have a period of incubation, are characterized by a fever of more or less intensity preceding the eruption, by an eruption which is peculiar to each, occurring most commonly in childhood, rarely attacking the same person twice, very prone to occasion serious sequelæ, and are contagious. Their origin is as yet undetermined.

## SCARLET FEVER.

**Synonym.** Scarlatina.

**Definition.** An acute, self-limited, *infectious* disease; characterized by high temperature, rapid pulse, a diffused scarlet eruption, terminating with desquamation, inflammation of the throat, and frequently more or less grave nervous phenomena. Serious sequelæ frequently follow an attack. One attack confers immunity from the disease.

**Pathological Anatomy.** An acute inflammation of the skin, with exudation—a true *Dermatitis*. A granular change in all the glandular structures, most marked in the Peyerian glands, although also occurring in the stomach and kidneys.

**Cause.** A specific poison, maintaining its vitality for a long time. Highly *contagious*, the contagion residing chiefly in the desquamated epidermis. Klebs' micrococci, the "monas scarlatinosum," may prove to be the poison. *Incubation* short, one to seven days.

**Varieties.** *Scarlatina simplex*, *scarlatina anginosa* and *scarlatina maligna*.

**Symptoms.** A mild case is a very trivial affection, but in its severest form there are few diseases more malignant.

Onset sudden with a decided *chill* and *vomiting* (in infants, convulsions), pain in throat followed by *high fever*, soon reaching  $105^{\circ}$ ; a *rapid pulse*, 110 to 140 being common. At the end of twenty-four hours a *bright scarlet rash* appears on the neck and chest, spreading

over the entire body within a few hours; the eruption is not raised, there is no intervening healthy skin, and scattered irregularly are points of a darker hue. With the appearance of the eruption occurs *burning heat of surface, burning in the throat and difficulty in deglutition*, the throat on inspection presenting the appearance of a *catarrhal* inflammation. Tongue at first furred, later, red, with prominent papillæ—the “strawberry tongue.” There also occurs *headache, great restlessness*, and in severe cases *delirium*. *Diarrhœa* quite common.

On the fourth or fifth day the fever declines by *lysis*, the eruption fading, and on the sixth or eighth day *desquamation* begins, continuing for a week or more, the *convalescence* being slow, the patient *emaciated and pale*.

*Scarlatina anginosa* are cases with the addition of great inflammation and swelling of the *pharynx, nose, palate, tonsils* and neighboring glands, the swollen glands pressing upon the surrounding parts, causing *difficulty of breathing and of deglutition*.

*Scarlatina maligna* are cases with decided *nervous* phenomena, to wit: *convulsions, delirium and muscular twitching*, the temperature reaching  $107^{\circ}$  to  $110^{\circ}$ , the *pulse rapid, feeble and irregular*, the *eruption delayed, of a purplish color, and in patches*.

**Sequelæ.** Chronic sore throat; conjunctivitis; otorrhœa; chronic diarrhœa; subacute rheumatism; chorea; endocarditis; pleuritis; acute Bright's disease and cutaneous dropsy.

**Diagnosis.** A typical case should cause no difficulty; the high fever, rapid pulse, sore throat, and early scarlet eruption, followed by desquamation, should leave no doubt.

**Measles;** the above symptoms are absent, and *catarrhal* symptoms present.

**Smallpox;** eruption on the third day in spots, changing to pustules with secondary fever.

**Dengue** or break-bone fever; absence of the above typical symptoms, and presence of severe *pains in the bones*.

**Diphtheria;** gradual invasion, great prostration, and no eruption, but the frequent complication of scarlatina and diphtheria must be remembered.

**Meningitis** may be suspected from the symptoms of *scarlatina maligna*; the epidemic influence, eruption, and rapid pulse, are points of difference.

**Prognosis.** Depends upon the character of the attack. Never

can be positive of the result. Mortality ranges from ten to twenty-five per cent.

**Treatment.** As with other eruptive fevers so with scarlatina; there are no specific remedies by means of which it can be arrested or controlled. Symptomatic treatment judiciously applied, however, may afford relief and diminish the fatality.

The indications are for good ventilation, isolation, disinfection, cooling drinks, action upon the skin and light nourishment.

For cases with high fever and rapidity of pulse, aconitum, digitalis, quinina or antipyrine, with cool sponging, cold bath, douche or pack.

If the surface be pale, the circulation feeble, and the eruption tardy in appearing, benefit will follow the administration of *tinctura belladonnae*, gtt. j-x, according to age.

For scarlatina anginosa, internal use of *tinctura ferri chloridi* and *potassii chloratis*, and stimulants. Externally, ice or cold compresses, unless they cause chilliness; if so, heat. Astringent gargles and small pellets of ice dissolved in the mouth are of use. The throat and nasal cavities are kept clean and the breathing relieved by the use of Dobell's solution used with a hand atomizer every hour.

Dr. J. L. Smith warmly lauds the following mixture for cases with decided *throat* symptoms:

R.	Acid boracic,	3 ss
	Potass. chlor.,	3 ij
	Tinct. ferri chlor.,	f 3 ij
	Glycerinæ,	
	Syrupi,	f 3 j
	Aquaæ,	f 3 ij.

SIG.—One tablespoonful every two hours, to a child of five years.

For *scarlatina maligna*, in addition to *ferrum* and *quinina*, the chief reliance must be on *alcoholic stimulants*, guiding the amount by their effects. In children wine-whey, milk-punch, and egg-nog are eligible for the administration of stimulants and nourishment.

For the *pruritus*, the local use of oils or fats in some form affords great relief, the following formula being most efficient, as well as a disinfectant:—

R. Acidi carbolici, . . . . . gr. x-xxx.  
Vaseline, . . . . . 3 ijij. M.

SIG.—To be applied over the entire surface after sponging or bath.

*Convulsions* result from the high grade of fever, or are the result of

uræmia. If due to the former cause, the cold bath and cold affusion are the indications; if the latter cause, the inhalation of *chloroformum* is indicated.

For the *headache*, *disturbance of vision and coma*, the result of uræmia, free purgation and diaphoresis with *pilocarpus* are to be employed.

Prof. Da Costa advocates the administration of *ammonii carbonas*, in small doses at frequent intervals, to prevent the liability of heart-clot, and for its salutary influence over the disease.

It is claimed that a characteristic micrococci is found in the blood, and that, consequently, the disease can be favorably influenced by *acidum carbolicum*, *thymol* or *acidum boricum*; an eligible way of administering acidum carbolicum is the *syr. ammoniæ phenatis* (Déclat), *f3 ss-f3 j*, four to six times daily.

For the various *sequelæ*, the treatment is the same as if they occurred primarily, *plus* tonics.

The disease being *infectious*, every means should be taken to prevent its spread, to wit: isolation, cleanliness, disinfection and fumigation.

Small doses of *quinina*, in those exposed, is said to prevent or modify the severity of an attack, but no true prophylactic is known.

## MEASLES.

**Synonyms.** Morbilli; rubeola.

**Definition.** An acute *epidemic* and *contagious* disease; characterized by catarrhal symptoms, referable to the naso-broncho-pulmonary mucous membrane, fever, and a crimson eruption which terminates by desquamation.

**Cause.** A specific poison, with a special susceptibility for childhood. Contagious by contact, and has been communicated by inoculation. One attack, as a rule, protects from a second. *Incubation*, ten days.

**Pathological Anatomy.** There are no special anatomical characters exclusive of the eruption which is considered among the symptoms of the disease.

**Symptoms.** Onset gradual, irregular *chills*, *fever*, the temperature rising to  $101^{\circ}$  or  $102^{\circ}$ , *muscular soreness*, *headache*, and intense *nasal*, *pharyngeal* and *laryngeal catarrh*; on the evening of the second day a decided remission takes place in the *fever*, the catarrh

continuing; on the *fourth day* occurs an eruption of a *crimson* color, on the face, soon spreading over the body, in the form of dots, slightly elevated, which coalesce into irregular circles or *crescents*, and with the appearance of the eruption the *fever returns*, the catarrh is aggravated, but the character of the *discharge*, instead of remaining clear and watery, becomes *turbid*, *thick* and *yellowish*, and extends to the bronchial mucous membrane. About the *ninth day* (the fourth of the eruption), the eruption fades, the symptoms abate, and slight desquamation occurs. Some cough and catarrh may remain for a long period.

*Black measles*, sometimes called *hemorrhagic rubecula*, or *camp measles*, is a variety occurring in camps and jails, in which occur dangerous chest symptoms, and black spots or petechiae from deteriorated blood, and severe prostration.

Rather common complications are *tonsillitis*, *lobar* and *catarrhal pneumonia*.

**Sequelæ.** In those of *strumous diathesis*, *scrofula* or *phthisis* may develop.

**Diagnosis.** A typical case begins gradually, with chilliness, nasal catarrh, watery eye, and fever, which decline before the eruption, rising afterward, the eruption crescentic in shape, and of a *crimson* color.

*Scarlet fever*; absence of catarrh, and earlier appearance and different character of the eruption with high fever and rapid pulse.

**Prognosis.** As a rule, a perfect recovery. If phthisis develop, the prognosis is bad. *Black measles*, the majority perish.

**Treatment.** *No specific.* Mild cases require no medicine, simply regulating the diet and bowels, and cool sponging; the indications are to render the patient as comfortable as possible, the disease pursuing a favorable course without therapeutical interference.

If the febrile reaction is high the following soon controls it:—

R. Tinct. aconiti rad., . . . . .	m ss-j
Spts. aetheris nitrosi, . . . . .	m x-xv
Liquor. potassii citrat, . . . . ad . . . . fʒj.	M.

Every two hours.

For the *pruritus* of the *eruption*, the local use of *oils* and *fats*. For *catarrhal symptoms*, inunction of the nose, neck and chest with *camphorated oil* and small doses of *pulv. ipecac et opii*, at bedtime; if the catarrh extends to the bronchial mucous membrane, *expectorants*.

During convalescence, for the strumous, protect from exposure, and administer *oleum morrhuae* with *syr. ferri iodidi*. For black measles, bold stimulation, with *ferrum* and *quinina*.

## RÖTHELN.

**Synonyms.** Epidemic roseola; German measles; French measles; false measles.

**Definition.** An acute, self-limited disease; characterized by mild fever, suffused eyes, cough and sore throat, enlargement of the lymphatic glands of the neck, and a rose-colored eruption, in patches of irregular size and shape, appearing on the first day.

**Cause.** Propagated by infection. That a peculiar germ exists is probable, but thus far it has not been isolated. *Incubation* from one to three weeks.

**Symptoms.** Onset sudden, with *mild fever, suffused eyes*, with little or no *coryza, sore throat*, and *enlargement of the cervical glands*, not limited to those about the angle of the jaw, as in scarlatina. Any time from the *first* to the *fourth* day appear *rose-colored spots*, size of a pin head, slightly elevated, which coalescing, form irregular shaped and sized patches, with intervening healthy skin, fading on the upper part of the body while just appearing on the lower. Symptoms all terminate within a week by *lysis*, the patient showing no ill effects from the attack.

**Diagnosis.** From *scarlet fever*, by absence of high fever, the rapid pulse, the color and character of the eruption and the sequelæ.

From *measles*, by absence of intense catarrhal symptoms, the late appearance of eruption and not of a crescentic shape.

**Prognosis.** Most favorable.

**Treatment.** Mild laxatives and restricted diet. If *fever* high, saline mixture. For *itching* of skin, sponging with vinegar and water.

## SMALLPOX.

**Synonym.** Variola.

**Definition.** An acute epidemic and *contagious* disease; characterized by severe lumbar pains, vomiting, and an initial fever, lasting from three to four days, followed by an eruption, at first *papular*, then *vesicular* and afterwards *pustular*; the development of the pustule

being accompanied by a *secondary fever*, during the presence of which grave complications are prone to occur.

**Causes.** A specific poison whose nature is unknown, maintaining its contagious vitality for a long period. There is no period, from the initial fever to the final desquamation, when the disease is not contagious, although the stage of suppuration is the most virulent. One attack, as a rule, protects from a second. *Vaccination* has a positive protective influence from the disease, an extensive observation having fully proven that in proportion to the efficiency of vaccination is the rarity and mildness of variola. *Incubation*, fourteen to sixteen days.

**Pathological Anatomy.** A granular and fatty degeneration occurs in the liver, spleen, kidneys and heart. The *pustules* are found in the larynx, trachea, bronchial tubes, and on the pleura.

**Varieties.** Discrete; confluent; malignant; varioloid or modified smallpox.

**Symptoms.** *Discrete form.* Onset sudden, with a violent chill, vomiting, and agonizing pains in the back, shooting down the limbs; fever, in short time rising to  $103^{\circ}$  or  $104^{\circ}$  F.; full, strong and rapid pulse, ranging from 100 to 130; the face red, eyes injected, intense headache and sleeplessness; delirium and convulsions occur at times. During the third day the characteristic eruption makes its appearance, first on the forehead and lips, consisting of coarse red spots; with the appearance of the eruption all the marked symptoms of the fever abate, the patient feeling quite comfortable. On the fifth day of the disease the spots become papules; on the sixth day, transformed into vesicles, which are soon umbilicated; on the eighth day the vesicles change to pustules; on the ninth day the pustules are entirely purulent, and each surrounded with a broad red band—the halo or areola, the face becoming swollen, and the features distorted; on the eleventh day, pus oozes from the pustules, and drying, forms the scab or crust, which, on the seventeenth to twenty-first day drops off, leaving a red, glistening depression or pit, soon changing into a white cicatrix. With the formation of the pustules (eighth day) severe rigors and fever set in, and a characteristic odor is emitted, all the original symptoms returning; this secondary fever is the most critical period of the disease, and is generally attended with violent delirium. In favorable cases the secondary fever subsides after three or four days, and convalescence is established.

*Confluent* smallpox differs from the *discrete* in the greater severity of all the symptoms and the marked prostration of the patient, the eruption appearing during the *second day*, the *pustules* coalescing into large patches, causing great distortion of the features.

*Malignant* smallpox is characterized by the greater intensity and the irregularity of the symptoms, death resulting before the characteristic eruption appears, by convulsions or coma. In these cases *hemorrhages* are frequent and *petechiae* are observed.

*Varioloid*, or modified smallpox, is the form modified by previous vaccination or by a former attack of smallpox. Its course is shorter and milder than the other forms, the eruption appearing a day later, and is *not attended with secondary fever*.

**Complications.** During the course of the *secondary fever* there is a great tendency to grave inflammations, such as *pleuritis*, *pneumonitis* and *dysentery*. During *convalescence*, *boils* and *abscesses* on the skin are frequent.

**Diagnosis.** Cannot be confounded with any other disease if have typical symptoms, such as chill, vomiting, pains in back and legs, high fever and pulse, all declining on *third day*, when the eruption appears, first spots, then papules, then vesicles, finally pustules, drying and forming crusts, and with the marked *secondary fever*.

**Prognosis.** Depends upon the *variety* of the attack, the *age* of the patient, and whether *vaccinated* or not. *Discrete*, mortality four per cent.; *confluent*, fifty per cent.; *malignant*, all perish; under *five years* and over *forty years*, fifty per cent. die.

**Treatment.** *No specific*; the disease will run its course under any plan of medication, although cases seem to do better if *acidum carbolicum*, *thymol* or the *sulphites* are used.

For the *initial fever* and the *full pulse*, relief follows the use of—

Rx.	Tinct. aconit. rad., . . . . .	gtt. j-ij
	Spts. æther. nitrosi, . . . . .	3 ss
	Liq. ammonii acetat., . . . . .	f 3 ij
	Aquee, . . . . .	f 3 iss. M.

Every hour or two.

*Antipyrine* should be serviceable in this stage, not only for the fever, but to relieve the pains.

If *headache* and *backache* are intense, hypodermic injections of *morphina*, or an *ice bag* to the head and along the spine.

For sleeplessness and restlessness or early delirium full doses of *potassii bromidum*, or *chloral*.

For secondary fever the best remedy is *quinina*, gr. v, every three hours, and for cerebral excitement of this period, either full doses of *potassii bromidum*, by stomach, or the following by rectum :—

R.	Chloral . . . . .	gr. xv-xx
	Mucil. acacia . . . . .	fʒ ij
	Aque . . . . .	fʒ ij.
p. r. n.		M.

The secondary fever being pyæmic in character, the depression should be anticipated by large doses of *tinct. ferri chloridi* and judicious stimulation, brandy in tablespoonful doses being most efficient.

From the onset, milk, eggs, animal broth, oysters and beef juice should be administered every three hours. Ice is always grateful and should be given freely, and if pustules appear in the mouth, ice should be held in the mouth as long as possible, and washes of *potassii chloras* or *acidum carbolicum* employed.

The disease being contagious, *isolation, ventilation, cleanliness and disinfection* are imperative.

To prevent pitting keep patient in a dark room, well ventilated. Masks of some unctuous material, thoroughly applied, to exclude the air, have a beneficial effect, a good formula being R. *Ung. hydrarg.*, *pulv. marante*, equal parts, or *glycerit. amyli*, painted over eruption, changing to *tinct. iodi* as vesicles are about to develop. Success is claimed by a number of observers from the use of *collodium* applied once or twice daily. Cold water dressings constantly to face and hands are beneficial, besides allaying heat, pain and swelling. Hot water can be used if more grateful.

## VACCINATION.

**Definition.** Inoculation with the matter of *vaccinia* or cow-pox — *bovine virus*. The person properly vaccinated is, as a rule, protected from an attack of smallpox, and especially from a severe or fatal attack.

Vaccination should be performed at least twice in every individual, to wit: during *infancy* and at *puberty*; and it is safer to have it again performed if special exposure be liable to occur.

In practicing vaccination the skin should be rapidly scraped until the true skin is reached and is ready to bleed, the lymph being then brushed over the abraded surface; or, instead, making three or four horizontal and transverse cuts, about four lines long, and rub the virus over them; a little blood, but not much bleeding, should be caused.

**Symptoms.** If the vaccination "takes," on the *third day* a *papule* appears; on the *sixth day* a *vesicle* has formed, with a central depression; on the *eighth day* a *pustule*, fully formed and distended with lymph, with a reddish areola, which becomes very wide. The areola begins to fade on the *tenth day*, the pustule begins to dry, and by the *fourteenth day* a *brown mahogany scab* or *crust* has formed, which is detached about the *twenty-third day*. The *cicatrix* is circular, depressed, radiated and foveated, becoming, after a time, paler than the surrounding integument.

During the course of a vaccination, more or less constitutional disturbance occurs, especially in children.

*Eczematous and papular* eruptions often develop in strumous children, for which the virus is unjustly held responsible.

## VARICELLA.

**Synonym.** Chicken-pox.

**Definition.** A mild, slightly contagious, febrile affection; characterized by a moderate fever, and the appearance of a *vesicular* eruption, drying up and falling off in from three to five days.

**Cause.** A peculiar poison; attacking only children; occurring sporadically and as an epidemic.

**Symptoms.** Moderate *fever*, thirst, anorexia and constipation, followed by the eruption of *vesicles*, which rapidly dry, and within the week drop off, leaving a slight *pit*. *Pustules* almost never occur. Symptoms are so slight, that, were it not for the vesicles, the affection would be often overlooked. The eruption appears on the *trunk* and *extremities*, very rarely on the forehead and in the mouth.

**Prognosis.** Most favorable.

**Treatment.** Entirely symptomatic. If vesicles on the face, efforts may be used to prevent pitting.

## ERYSIPelas.

**Synonyms.** Erysipelatous dermatitis; the rose; St. Anthony's fire.

**Definition.** An acute, specific, infectious disease; characterized by a fever of low type, and a peculiar inflammation of the skin, generally of the neck and face. This inflammation exhibits a marked tendency to spread, to induce serous infiltration and suppuration of the areolar tissue, and to affect the lymphatic vessels and glands.

**Cause.** A poison, the nature of which is unknown. *Feebly contagious.* One attack predisposes to another. The etiology of idiopathic (medical) and traumatic (surgical) erysipelas are identical.

**Symptoms.** Onset sudden; a *chill*, followed by *fever*, which soon reaches  $104^{\circ}$  or  $105^{\circ}$ , *frequent pulse*, 100 to 130, coated tongue, *nausea* and *vomiting*, severe pains in the limbs, with *epistaxis* in adults and convulsions in children, and often *diarrhœa*.

*Delirium* is frequent, and in those of alcoholic habits it resembles *delirium tremens*.

The *eruption* soon follows the *chill*, beginning in *red spots*, which rapidly coalesce and spread; a sense of *heat*, *tension* and *tingling* is caused by the *great adema*, which presents a *tense, shiny* appearance, the swelling being so great at times as to close the eyes and distort the features. In many cases *small vesicles* develop, which may coalesce, forming *blebs*, of considerable size, containing a clear yellow serum. After five or six days the eruption begins to subside the symptoms abate, the part affected becomes tender, and there is moderate desquamation.

During the height of the attack *albumin* appears in the urine, so that the possibility of *uræmic* symptoms must be remembered.

When extensive *infiltration* into the *areolar tissue* occur, the swelling and tension become greater, and it is termed *phlegmonous erysipelas*.

When the *eruption* spreads to different parts of the body, it is termed *erysipelas ambulans*.

**Complications.** *Thrombosis* of cerebral capillaries or sinuses, or as it is sometimes called, "erysipelas of the brain," is explained by the intimate anatomical connection of the facial vein with the pterygoid plexus and cavernous sinus.

*Edematous laryngitis*, from extension to the larynx.

Pneumonia, pleurisy and meningitis are frequent complications.

**Diagnosis.** Not difficult. The fever, early spreading eruption, with burning, swelling, tension and tingling, and albuminous urine, separate it from the other *eruptive fevers* and *erythema*.

**Prognosis.** Usually favorable. Unfavorable if it attack drunkards; if it becomes gangrenous; if thrombosis of sinuses occur, or if it extends to the larynx.

The convalescence, even from the mildest attack, is slow, the patient continuing weak and anæmic for a long time.

**Treatment.** Mildest cases only require a *laxative*, nourishing diet, and locally *vaseline* or *bismuth oleat.*, to modify the heat and burning.

Prof. Da Costa strongly urges the use of *free purgation* before the use of the remedies usually *administered*.

According to Reynolds, *aconitum* will cut short an attack. He administers  $m \frac{1}{2}$ -j, every fifteen minutes for the first two hours; then in hourly doses, until the surface is moist and the temperature lowered. The author corroborates this plan, from a personal experience.

In severe cases, *tinct. ferri chlor.*, gtt. xx-xxx, every third hour, well diluted. Also *quinina* in gr. ij, every third hour. *Ext. belladonnae*, gr.  $\frac{1}{4}$ , added, with benefit. The diet from the onset should be of the most nourishing character, and administered at regular intervals. Dr. Waugh strongly lauds *extractum pilocarpi fluidum* in *erysipelas*.

Prof. Da Costa reports excellent results in cases with *rapid spreading* tendency, from the use of *pilocarpinæ hydrochloras*, gr.  $\frac{1}{6}$ , hypodermically or *ext. pilocarpi fluidum*, gtt. xx-xl, every two hours. Or good results are obtained in a fair number of cases from *potassii iodidum*.

Cerebral symptoms, *stimulants*, *opium* and *chloral*

Extension to *throat*, *argenti nitras*, brushed over parts. If symptoms of *oedema* of the glottis develop, *tracheotomy* is indicated.

Locally, soothing applications are indicated, to wit: *Vaseline*, *ung. zincii oxidi*, *ol. olivæ cum glycerinæ*, *bismuth oleat.* or *ungt. hydrargyrum*.

In *phlegmonous* variety, *argenti nitras*,  $\mathfrak{A}$ j, *spts.* *atheris nitrosi*,  $\mathfrak{Z}$ ij, brushed over and beyond the affected part, with the internal use of large doses of *quinina*, *ferrum* and *stimulants*.

## DENGUE.

**Synonyms.** Break-bone fever; neuralgic fever; dandy fever.

The word *dengue* is pronounced *dangay*.

**Definition.** An acute, epidemic, febrile disease, consisting of two paroxysms of fever with an intermission. The first paroxysm is characterized by high fever, distressing pains in the joints and muscles, and a peculiar eruption; the second paroxysm is characterized by a milder fever, an eruption of different character, attended with intense itching, by some recurrence of the joint pains, and by debility.

**Cause.** Unknown; but it is evident that a peculiar condition of the atmosphere has some influence in its development.

**Symptoms.** Onset sudden—*fever*,  $103^{\circ}$  to  $105^{\circ}$ , intense *headache*, *burning pains in the temples, backache*, severe *aching and swelling of the joints and stiffness of muscles*, nausea, vomiting, constipation and the appearance of a *rash*, resembling scarlatina, from which the disease has been mistaken for scarlatinal rheumatism. After some hours to two or three days, a distinct *intermission* obtains, of one or two days' duration.

The onset of the second paroxysm is also sudden, but the symptoms are much less severe, although the patient is greatly *debilitated*; it is at this time that the characteristic eruption appears, being either *erythematous* or *rubeolous*, and attended with *intense itching*, remaining for about two days, when desquamation occurs and convalescence is established, but is prolonged by the great debility of the patient. Average duration of the disease eight days. *Relapses are common.*

**Diagnosis.** Most apt to be mistaken for *acute articular rheumatism*, especially during the *first paroxysm*, but the course of the disease and the epidemic influence should prevent such an error.

The eruption might mislead for *scarlet fever* or *measles*, were it not for the severe joint and muscular pains.

**Prognosis.** Favorable.

**Treatment.** *No specific.* Entirely symptomatic.

At the onset, free *purgation and diaphoresis*.

For the *fever*, *quinina*, gr. v every five hours, or *antipyrine*, gr. x-xx, repeated p. r. n.

For the *pains*, *opium* or *acidum salicylicum*.

For the *itching*, lotion of *acidum carbolicum*.

## DISEASES OF THE MOUTH.

### CATARRHAL STOMATITIS.

**Synonyms.** Simple stomatitis ; erythematous stomatitis ; catarrh of the mouth.

**Definition.** An acute catarrhal inflammation of the whole or a portion of the mucous membrane of the mouth and tongue, characterized by pain, redness, swelling and disordered secretion. Most common in infants and children. Chronic stomatitis occurs mostly in adults, the result of alcoholic or tobacco excesses.

**Causes.** Introduction of hot and irritating substances into the mouth ; difficult dentition ; secondary to disorders of the stomach, to measles, scarlet fever and variola.

**Pathological Anatomy.** The buccal mucous membrane and tongue have a dark red appearance, are much swollen, the tongue often appearing as if too broad to lie between the teeth, the sides showing the impressions of the teeth ; the secretions are at first lessened, afterward increased, a turbid mucus covering the cheeks, gums and tongue, thus giving a *coated tongue*.

**Symptoms.** Oral catarrh begins with a *burning, smarting pain*, and *tension* in the mouth, in those old enough to describe their suffering. Very young children *refuse to nurse* or allow their mouth to be touched, have *slight fever*, disordered stomach, are *fretful* and *sleepless, craving cooling drinks*.

The sense of taste is blunted, and there is usually an unpleasant bitter taste in the mouth.

If the catarrh becomes *chronic*, the breath has a fetid odor and the tongue is coated in the morning, the taste is disordered, and there is generally more or less depression of spirits.

**Diagnosis.** If the buccal cavity be examined, the condition is readily discerned.

**Prognosis.** Recovery is the rule for the acute variety.

The *chronic* cases are usually due to the use of tobacco or alcohol, and are only modified by the absolute withdrawal of the exciting cause.

**Treatment.** The most important point in the treatment is the removal of the exciting cause, attention to the secretions and diet, and

Locally—

R. Sodii boratis, . . . . . 3 iss  
 Aquæ destillat., . . . . . fʒj  
 Mel. rosæ, . . . . . fʒj.

## FOLLICULAR STOMATITIS.

**Synonyms.** Aphthæ; vesicular stomatitis; croupous stomatitis.

**Definition.** An acute inflammation of the follicles and mucous membrane of the mouth and tongue, characterized by a fibrinous or croupous exudation; the exudation first appearing in isolated spots (*aphthæ discrete*), afterward coalescing, and forming large and irregular-sized patches (*aphthæ confluens*), which rupture, leaving an ulcer, which slowly heals.

**Causes.** A disease principally of childhood. Difficult detention; disorders of digestion; uncleanliness, such as neglect to rinse the child's mouth after nursing; with measles and diseases of the buccal cavity.

**Pathological Anatomy.** Begins as a small, whitish papulo-vesicular elevation, semi-transparent, hard and tender, with a distinct red zone about their base; there may be as few as six or as many as twenty; they may remain isolated (*aphthæ discrete*) or coalesce (*aphthæ confluens*); they are regarded as either a peculiar deposit or a local croupous exudation. After a day or two they rupture, leaving an irregular white or grayish ulcer, which slowly heals. The seat of the affection is the internal surface of the lips and cheeks, the gums, tongue and roof of the mouth.

**Symptoms.** In infants, the *pain* is so severe that the child refuses to nurse. In older children, *pain* from *talking*, *mastication* and *deglutition*. *Salivation* is marked, the saliva dribbling from the mouth. There is slight *feverishness*, *fretfulness* and *sleeplessness*. *Digestion* is impaired, and quite commonly *diarrhœa* occurs. A *disagreeable, penetrating odor* escapes from the buccal cavity.

**Diagnosis.** Impossible to confound with any other affection if the buccal cavity is examined.

**Prognosis.** Always favorable.

**Treatment.** Removal of the exciting cause. Attention to the *dietary* and the *secretions* is paramount.

*Internally*, excellent results follow the use of *potassii chloras*,

gr. j-ijj, every three or four hours, according to the age. Protracted cases require tonic doses of *quininæ sulphas*.

Locally, good results are obtained from strong solutions of *potassii chloras, infusum coptis* or *bismuth*, applied directly to the ulcers.

## ULCERATIVE STOMATITIS.

**Synonyms.** Diphtheritic stomatitis; gingivitis ulcerosa.

**Definition.** An acute diphtheritic inflammation of the mucous membrane of the mouth, continuing until extensive and unhealthy *ulceration* occur. It usually begins on the margin of the *lower gums*, and often extends to the lips, cheeks or tongue.

**Causes.** Usually seen in children only. Most frequently in the families of the poor, the result of unfavorable hygienic surroundings, personal uncleanliness and poor food. Often seen in those reduced by severe acute disease. Perhaps contagious, as *epidemics* are not rare.

**Pathological Anatomy.** The *gums* first appear congested, swollen, bleeding readily and separated from the teeth; soon a firmly adherent deposit in the form of patches appears, at first whitish, speedily becoming gray or even black, from disintegration, becoming soft and pulpy, the separated slough leaving irregular-shaped *ulcers*, with raised margins, from *œdema* of the surrounding tissue. They are not deep, and their surface is covered with a pulpy, yellowish substance. The morbid process usually extends to the inner side of the lips, cheeks and to the tongue.

**Symptoms.** *Pain* constantly, aggravated by *mastication* or *deglutition*: food and drink must be of the blandest character. The mouth is *hot*, the *saliva* *dribbles* away, mixed with *blood* and shreds of *pulpy matter*, the *breath* is *fetid*, the appetite, digestion and bowels disordered. The patient is feverish, fretful and sleepless.

There is always enlargement and tenderness of the submaxillary glands.

The affection is often associated with *entero-colitis*.

**Diagnosis.** Apt to be confounded with gangrenous stomatitis, than which, however, there is less constitutional symptoms and a slower course of the malady.

**Prognosis.** Favorable. If promptly and properly treated, the

ulcerated surface rapidly heals, although quite commonly some teeth are lost.

**Treatment.** The etiology of the affection must be borne in mind and remedied. Strict attention to the diet, to the secretions, and absolute cleanliness.

*Internally*, the prompt use of *potassii chloras*, gr. j-v, frequently repeated, often acts like a specific. The general health often calls for *quinina*, *ferrum* and *stimulants*.

*Locally*, a strong solution of *potassii chloras*, or keeping the ulcer covered with *bismuth*, or frequent applications of *alumen exsiccatum* are valuable. Cases which resist these remedies should have applied the following combination, proposed by the late Dr. Dewees:—

R.	Cupri sulphat., . . . . .	gr. x
	Pulv. cinchonæ opt., . . . . .	3 ij
	Pulv. g. arab., . . . . .	3 j
	Mel. commun., . . . . .	f 3 ij
	Aquæ font, . . . . .	f 3 ij.
	Ft. sol.	M.

SIG.—The ulceration to be touched twice daily, with the point of a camel's-hair pencil.

If a spreading tendency occur, the application of *argenti nitras dilutus*, or a diluted solution of *acidum nitricum* is indicated.

## THRUSH.

**Symptoms.** Muguet; sprue; white mouth.

**Definition.** An inflammation of the mucous membrane of the mouth, associated with or caused by the growth of a *parasitic plant*, the *oïdium albicans*; characterized by pain, disorders of digestion and of the bowels.

**Causes.** The development of the thrush-fungus, *oïdium albicans*, is promoted by all those conditions designated as unhygienic, by debilitated conditions of the general system, and by neglect to thoroughly rinse the mouth after nursing or bottle feeding.

The age is considered a predisposing cause, seldom being seen after two years of age. In adults, only toward the last stages of cancer or consumption.

**Pathological Anatomy.** The mucous membrane of the mouth assumes a dark red appearance in isolated patches, on which whitish points appear, which rapidly coalesce into large areas. They closely

resemble curdled milk, from their soft consistency. These whitish points consist of epithelium and fat, in which are embedded the sporules and filaments of the fungus.

The deposit first appears about the angles of the mouth, soon extending to all parts of the cavity, often to the pharynx and cesophagus.

The mouth is usually swollen and tender, the breath often fetid.

**Symptoms.** *Pain*, aggravated by *nursing* or *mastication*. The lips are swollen, the *saliva* is *increased*, the *breath* hot and somewhat fetid. There is usually increased temperature. *Diarrhwa* is frequent, the stools green and sour, causing an erythema of the buttocks.

**Diagnosis.** The curd-like appearance of the deposit, showing the presence of parasites upon microscopical examination, will prevent error.

**Prognosis.** Favorable, unless occurs toward the termination of exhausting diseases.

**Treatment.** Absolute cleanliness of the mouth is all important.

*Internally*, remedies should be directed to the removal of the disorders of the gastro-intestinal tract.

Prompt relief has followed the use of *sodii hyposulphitis saturat.* *solut.*, *gtts. iij-x*, every two or three hours, and the local application of the same solution.

*Locally*, solutions of *sodii boras* often answer every indication, the best vehicle being *glycerinum*, and not *mel* or *saccharum*, a good formula being—

R.	Sodii boratis, . . . . .	3j	
	Glycerini, . . . . .	f 3ij	M.
	Aquæ, . . . . .	3vj.	

**Sig.**—Thoroughly applied four or five times daily, and continued for a week after the disappearance of the affection.

## GLOSSITIS.

**Definition.** An inflammation of the parenchyma of the tongue; characterized by great swelling of the organ, with difficult mastication, deglutition and vocalization.

The affection may be either *acute* or *chronic*.

**Causes.** The *acute variety* is usually the result of some direct irritation to the tongue, such as direct injury, contact of boiling

liquids, the action of acrid or corrosive substances, or the sting of the tongue by an insect, such as the bee or wasp.

The *chronic variety* is generally circumscribed; it may follow the acute; be due to the sharp edges of the teeth, or the use of a tobacco pipe.

**Pathological Anatomy.** *Acute glossitis* begins with intense hyperæmia, redness and swelling of the organ; the size often becomes so great that the tongue is too large for the mouth, and thus protrudes between the teeth; its surface is covered with a thick secretion, and it becomes of a pale or grayish color. The swelling may rapidly decline, or abscesses may form, which leave a more or less decided depressed cicatrix.

*Chronic glossitis* occurs usually along the edges of the organ, the cicatricial changes being in circumscribed hard spots. If the entire tongue is affected with chronic inflammation, the action is superficial, and has been termed "psoriasis of the mouth."

**Symptoms.** *Acute glossitis* begins rather abruptly with *fever*, increased *pulse*, *restlessness*, *anxiety*, *enlargement* of the *tongue*, a sensation of *heat* in the mouth, with *pain*, and increased flow of *saliva*. *Mastication* and *deglutition* become difficult if not impossible, the *voice muffled* and *dyspnœa* decided. The *glands* at the angles of the *jaw* are *enlarged*, which, in turn, compress the vessels of the *neck*.

When *suppuration* supervenes, the constitutional symptoms become severe and the oral symptoms are intensified. *Death* has occurred from suffocation in severe cases.

*Chronic glossitis* presents *pain* as the chief symptom, aggravated by movements of the organ.

**Diagnosis.** The rapid course of *acute glossitis* should prevent its being mistaken for any other affection.

*Chronic glossitis*, if severe, might be mistaken for *cancer* of the tongue, although the slow and mild progress of the former contrasts strongly with the rapid, severe and painful course of the latter, with its marked constitutional symptoms.

**Prognosis.** *Acute glossitis* usually terminates in recovery within a week, although the danger of suffocation must always be remembered.

*Chronic glossitis* is an incurable malady in the majority of instances.

**Treatment.** For *acute glossitis* prompt measures are demanded.

For the *fever* and *rapid pulse*, *tinctura aconiti*, gtt. j to iij every half hour or hour until its physiological effects are produced.

For the *enlargement* of the organ, either *ice* constantly applied internally and externally, at the angles of the jaw, or the persistent use of *hot water* held in the mouth and externally; if prompt relief does not follow these measures, or if the case is an aggravated one, the prompt *deep scarification* of the tongue must be resorted to.

If *abscesses* form, promptly open them and administer *quinina*.

If *suffocation* appear imminent, *tracheotomy* must be performed.

For *chronic glossitis*, the removal of the exciting cause and the local use of *argenti nitratas* to the ulcerated edges.

"For *psoriasis* of the tongue," the local use of *argentum* or *acidum carbolicum*.

The general health must always receive due attention.

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## DISEASES OF THE STOMACH.

### ACUTE GASTRIC CATARRH.

**Synonyms.** Acute mild gastritis; gastric fever; bilious fever; acute indigestion; subacute gastritis.

**Definition.** An acute catarrhal inflammation of the mucous membrane of the stomach; characterized by feverishness, loss of appetite, nausea, with occasional vomiting, painful digestion, irregularity of the bowels, and in severe attacks, vertigo (*stomachic vertigo*).

**Causes.** Deficient quantity of or quality in the gastric juice. Errors in diet, insufficient mastication of food, swallowing liquids which are either too hot or too cold, and particularly the abuse of alcoholic liquors.

Often secondary to infectious diseases, such as scarlet fever, measles, smallpox, diphtheria and typhoid fever. Occasionally the result of sudden changes of temperature.

**Pathological Anatomy.** The mucous membrane is irregularly congested and engorged, and covered with a grayish, semi-transparent and *tenacious mucus*, having an *alkaline* reaction. The *true gastric juice* is secreted in *lessened amount* or is *entirely suspended*.

**Symptoms.** At first, *loss of appetite*, at times *disgust for food*, heavily coated tongue, bad *taste* and *breath*, persistent *nausea*, and at times, *vomiting*, first of undigested food, then viscid mucus, acid and bitter, and finally, bilious matter; moderate *irritative fever* is present, with *headache*, considerable *thirst* and flashes of heat with sensations of burning in the palms of the hands and soles of the feet; *acid drinks* eagerly sought after; *digestion imperfect*, giving rise to *pain*, *tenderness*, *feeling of weight* and *eructations*; bowels often loose, sometimes, however, constipated. *Vertigo* with *pain* in the *nucha*, is a prominent symptom in many cases, causing great anxiety and depression of spirits. The *urine* is scanty, containing *lithates* and *pigment*.

The symptoms are aggravated by errors in diet, and if saccharine or fatty articles are taken, *heartburn* occurs.

Towards the termination of an attack, *herpetic eruptions* appear about the mouth.

**Diagnosis.** Acute gastric catarrh with fever, may be confounded with *remittent* and *typhoid fever* of the first week, but all doubts will disappear as these maladies develop.

The *vertigo* may be mistaken for *cerebral disease*, but the disappearance of this symptom when stomachic treatment is inaugurated removes all apprehension.

**Prognosis.** Favorable. Duration about a week; recovery slow, even under treatment, as far as perfect digestion is concerned.

**Treatment.** Give the stomach as complete *rest* as possible. If the stomach is overloaded, an *ipecac emetic* is indicated, or if vomiting has begun, it may be encouraged by swallowing large draughts of hot water, which will act as a sedative if the stomach be empty. *Irritability of the stomach* is readily controlled by—

R.	Hydrarg. chlor. mitis,	gr. $\frac{1}{20}$ — $\frac{1}{10}$
	Sodii bicarb.,	gr. ij
	Pulv. aromat.,	gr. v.

M.

Every two hours,

which has the additional advantage of relieving the bowels, or—

R.	Bismuthi subnit.,	gr. xv
	Acid. hydrocyanici, dil.,	mij
	Mucil. acaciæ,	f $\frac{3}{3}$ ss
	Aq. menth. pip.,	f $\frac{3}{3}$ iss.

M.

**SIG.—**Every two or three hours.

Many cases are rapidly benefited by one or two drop doses of *tinctura nucis vomicis* every hour.

Weak alkaline mineral waters or *liquor calcis*, should be freely used.

After the acute symptoms have subsided—

R. Strychninæ sulph., . . . . .	gr. $\frac{1}{6}$
Acid hydrochlor. dil., . . . . .	gut. x
Tinct. gent. co., . . . . .	fʒj.

M.

*Before meals*, will improve the appetite and digestion.

### ACUTE GASTRITIS.

**Synonym.** Toxic gastritis.

**Definition.** An acute and violent inflammation of the mucous, submucous and muscular coats of the stomach, with loss of tissue; characterized by great pain, constant vomiting of blood-streaked or bloody mucus and symptoms of collapse.

**Causes.** Ingestion of irritant and corrosive poisons, such as the mineral acids, arsenic, corrosive sublimate, copper and carbolic acid.

**Pathological Anatomy.** The mucous membrane is vividly red and injected, more marked at some portions than at others; it is soft and friable; erosions are irregularly scattered, and the submucous, muscular, and at times serous coats show decided destructive changes. The gastric tubules are destroyed in large numbers. In many cases the *oral* mucous membrane presents signs of severe inflammation.

**Symptoms.** Immediately or soon after swallowing the irritant there ensues a deadly *nausea*, with rapid and *persistent vomiting*; first, of the contents of the stomach acted upon by the poison, afterward, shreds of mucous membrane and blood clots; there are also present great *anxiety* and *depression*, a *weak, rapid pulse, slow and shallow respiration, cold skin, covered with a cold sweat, intense burning heat at the epigastrium, thirst with burning in the fauces and gullet, and exhaustive purging*; the features are more or less retracted or sunken; these symptoms terminating in collapse and death, or slow convalescence and recovery with a crippled stomach.

A *diagnosis* of the character of the poison swallowed is often afforded by the *stain* of the lips, face and mucous membrane, to wit: *sulphuric acid*, blackish eschar; *nitric acid*, yellowish eschar; *caustic*

*potash*, spreading widely and softening the tissues; *corrosive sublimate*, whitish or glazed; *carbolic acid*, white and corrugated.

**Prognosis.** Very grave. Many perish from shock, and the destruction of the mucous membrane, which prevents nourishing. Early treatment when no perforation of the walls of the stomach has occurred and recovery is possible, the organ being ever after much weakened.

**Treatment.** At once, hypodermic injection of *morphina*, repeated at regular intervals.

*Vomiting* should be encouraged by the free use of *demulcents*.

If the case be seen within a short period of the swallowing of the poison, the proper antidote should be used; but if some hours have elapsed, it is useless. *Ice*, internally and externally, gives great relief. The stomach should be washed out with the stomach pump, thereby removing any remaining poison, while at the same time it acts as a sedative to the inflamed membrane; also *bismuthi subnit.*, grs. xx-xxx every hour or two, is beneficial.

*Milk* and *lime water* is the only food that should be given by the stomach, *enemata* being used to support the system.

## CHRONIC GASTRIC CATARRH.

**Synonyms.** Chronic gastritis; chronic dyspepsia; drunkards' dyspepsia.

**Definition.** A chronic catarrhal inflammation of the stomach, with thickening of the coats and atrophy of the gastric glands; characterized by tenderness over the epigastrium, impaired appetite, painful and imperfect digestion, thirst, and great depression of spirits or melancholia.

**Causes.** Repeated attacks of acute gastric catarrh; habitual use of spirituous liquors; malaria; disease of the heart, lungs, pleura or liver, producing chronic congestion of the stomachic vessels; cancerous or other degenerative diseases of the stomach.

**Pathological Anatomy.** The mucous membrane is of a brownish or slate color, elevated into ridges from hypertrophy, the result of constant congestion; the peptic glands first increase in size, then undergo granular change, atrophy of their cells resulting. The mucous membrane is covered with a thick, alkaline tenacious mucus. These changes may affect the entire organ or be limited in extent.

**Symptoms.** *Loss of appetite*, disagreeable feeling of *gnawing* and at times *fullness* in the stomach, *tenderness* at the epigastrium, but slightly influenced by eating, *prominence* of the epigastrium, from distention by decomposing gases, occasional *nausea* and *vomiting*, the latter more common in drunkards, occurring on arising, termed *morning vomiting* and consisting of glairy mucus raised after great retching; *constant thirst*, water and at times stimulus being craved; often great *burning* at the pit of the stomach, the result of acidity; *bowels constipated*, *urine high colored*. A feeling of *mental depression* and *sleeplessness*, with occasional attacks of *vertigo*, add to the misery of the patient. *Follicular pharyngitis* of an aggravated type adds to the general distress of the patient. The imperfect digestion causes more or less *loss of flesh*, the fat disappearing, the muscles relaxed and the skin dry.

**Prognosis.** Favorable as to life, but not as to complete recovery, the atrophied glands more or less hindering digestion and assimilation.

**Treatment.** Regulated diet. Avoid fatty, saccharine and starchy food. A milk diet is beneficial, to which may be added beef in small amounts, eggs, oysters and a few fresh green vegetables. Avoid all *tonics, bitters, or acids, unless specially indicated*.

Locally, a few *leeches*, *dry cups*, a *blister*, or *emplastrum belladonnæ* over the epigastrium.

Purgatives are doubly indicated; *first*, relieving the constipation; and *second*, clearing the stomach of the tenacious mucus, which neutralizes what gastric juice is secreted. Appropriate purgatives are the natural mineral waters, such as Saratoga or Friedrichshall, or—

R. Magnesii sulph., . . . . .	3 i-ij
Sodii et potass. tart., . . . . .	3 ss-j
Acid. tartaric, . . . . .	gr. xx. M.

Dissolved in a glass of water and drank, effervescing, an hour before breakfast.

Digestion may be temporarily aided by *pepsinum* or *lactopeptin* with the meals.

Great relief follows the systematic drinking of one-half to one pint of *hot water* an hour before meals.

For the morbid condition itself may be used, *liq. potassii arsenitis*, gtt. i-ij before meals, or *bismuth subnit.*, gr. x-xx, before meals, to which may be added *sodii bicarb.*, gr. v; or *argenti nitrat.*, gr.  $\frac{1}{4}$ - $\frac{1}{3}$ ,

or *argenti oxidum*, gr.  $\frac{1}{2}$ -j, in pill, before meals, or *acidum hydrochloricum dilutum*, in water, before meals.

Pain is so severe in some cases that resort must be had at times to *opium* or *belladonna* in small doses, after meals.

Rest of the body is almost as imperative as rest of the stomach.

## GASTRIC ULCER.

**Synonyms.** Chronic gastric ulcer; perforating ulcer.

**Definition.** A solution of continuity, involving the mucous membrane and one or more layers of which the walls of the stomach are composed; characterized by pain, disorders of digestion and vomiting of blood.

**Causes.** Anæmia or its sequelæ the chief factor. Most common in young anæmic women. Virchow claims that *emboli* or *thrombi* form in the nutrient gastric arteries which have lost their tonicity, an ulcer forming at the point of obstruction.

**Pathological Anatomy.** In the majority of cases the ulcer is solitary. The posterior wall near the pylorus is the most common site.

In a typical case there is a circular hole, with sharp borders in the serous coat of the stomach; the loss of substance is greater in the mucous membrane than in the muscular coat, and greater in this than in the serous coat, so that the ulcer looks like a shallow funnel, the apex at the outer wall, the base at the inner wall of the stomach; it is first round, growing, becomes elliptical, bulging at portions, becoming irregular; size, from  $\frac{1}{4}$ - $\frac{1}{2}$  inch in diameter. When the ulcer heals before all the coats are perforated, a distinct cicatrix marks the location. During its progress nutrient vessels are eroded, causing profuse hemorrhage. Chronic gastric catarrh complicates the majority of cases.

**Symptoms.** More or less prominent symptoms of indigestion. Pain constant at the "pit of the stomach," increased by taking food, especially of an irritant kind, the pain often felt in the back, of a *burning, gnawing* character. Tenderness at one or more points, extending from the front to the back. Vomiting is almost as constant as pain, coming on soon after eating if the ulcer is at the cardiac orifice, an hour or so after if it is at or near the pylorus. Rejected matter may be undigested or partly digested food, or simply acrid mucus.

*Vomiting of blood* in large quantities and arterial in color is almost diagnostic of gastric ulcer; the blood may be dark in color if it has remained in the stomach some time before being rejected.

Severe and frequent attacks of *gastralgia* may add to the suffering of the patient. The general condition of the patient is not significant, some being greatly debilitated, while in others the nutrition is but little deranged.

**Duration.** The ulcer is slow in forming, and runs a very chronic course, an average duration being, perhaps, a year. Cases are recorded in which the disease has suddenly developed and terminated by *perforation, peritonitis* and *death* within two weeks, but such are rare.

**Diagnosis.** *Duodenal ulcer* presents symptoms so akin to those of gastric ulcer that a differential diagnosis is impossible.

*Chronic gastritis* is often confounded with gastric ulcer; the distinctive points are, absence of vomiting of blood, no localized constant pain aggravated by food, and no tenderness in the back; while the symptoms of indigestion are marked and persistent, with, as a rule, a history of spirit drinking, and the age of the patient—middle life; *ulcer in the young*.

The points of distinction between *gastric cancer* and *gastralgia* will be pointed out when considering those affections.

**Prognosis.** Not very unfavorable. Recoveries are frequent. The dangers are *perforation, peritonitis* or *fatal hemorrhage*.

**Treatment.** Give the stomach as complete a rest as possible; this is accomplished by *rectal alimentation*, or where it cannot be carried out, exclusive *milk diet*, adding *lime water*, to enable the stomach to better retain the milk; the amount of milk should be one or two ounces every two hours. *Rest in bed* is paramount, and should be insisted upon.

For *pain*, small doses of *morphina* should be used as needed.

For *hemorrhage*, hypodermic injections of *ergota* are most reliable. *Plumbi acetas*, gr. j-iij, arrests the bleeding and exercises a favorable influence over the ulcer.

For the *ulcer*, *liq. potassii arsenit.*, gtt. j-iij every five hours, has given excellent results in several cases treated by the author; *bismuthi subnitrat.*, gr. xx-xxx, combined with *sodii bicarb.*, gr. iij-v, three times a day, often does well; *argenti nitras*, gr.  $\frac{1}{4}$ - $\frac{1}{3}$ , every four hours, or *argenti oxidum*, gr. ss. every four hours, are at times beneficial.

If *perforation* and *peritonitis* result, full doses of *opium* are indicated.

## GASTRIC CANCER.

**Synonyms.** Cancer of the stomach ; gastric carcinoma.

**Definition.** A peculiar malignant growth, occurring for the most part at the pyloric extremity of the stomach, making constant progress, destroying the gastric tissues and infecting the lymphatic glands ; characterized by disorders of digestion, pain, vomiting, marked anæmia, and terminating in all cases by the death of the patient.

**Cause.** Hereditary. Develops after forty years, for the most part.

**Pathological Anatomy.** Cancer of the stomach is the most common form of cancer. It is, as a rule, a primary cancer. The variety is most commonly the *scirrhous*, next in frequency, *medullary*, the least frequent, *colloid*. As regards the location, eighty per cent. occur at the *pylorus*.

It originates usually in the *tubules*, rapidly infiltrating the remaining tissues, thickening everywhere as it progresses, and either remains a hard nodulated mass or undergoes ulceration. The hard nodulated growth at the pylorus constricts the orifice, resulting in dilatation of the stomach. The lymphatic glands adjacent to the stomach are infiltrated, secondary cancers resulting. Ulceration into an artery causes hemorrhage into the peritoneum, resulting in local peritonitis.

**Complications.** Fatty heart ; thrombosis ; tuberculosis.

**Symptoms.** The development of gastric cancer is insidious with *indigestion*, progressive in character, associated with *marked acidity*, *flatulency* and a *fetid breath*.

The majority of cases have *vomiting* immediately after eating, if at the cardiac orifice, and some hours after it at the pylorus ; if much dilatation of the stomach develop the vomiting occurs some days after eating. The rejected matter is food in various stages of digestion, associated frequently with *black grumous masses* of altered blood. *Pain*, marked and constant, *dull*, *heavy*, increased by pressure, seldom lancinating. Marked *anæmia*, *emaciation*, are present, the surface having an *earthy* or *fawn color*. *Œdema* of the ankles is an early diagnostic symptom in carcinoma of the stomach, often occurring as early as the third month. A *tumor* is found in three-fourths of the cases, occupying the epigastric region, *not moving with inspiration*.

The duration of the disease is about one year, the patient dying from *exhaustion*, *peritonitis*, or *hemorrhage*.

**Diagnosis.** The continuous presence of free hydrochloric acid

in the stomach is a diagnostic sign of great value in excluding the probable existence of gastric cancer. *Chronic gastric catarrh* differs from gastric cancer, in the absence of a tumor, bloody vomit, characteristic pain, peculiar color of the surface, dropsy and the rapid emaciation.

*Gastric ulcer* differs in the character of the pain, age of the patient, large amount of bloody vomit, absence of a tumor and progressive emaciation. Still the diagnosis is often difficult.

*Abdominal tumors* may raise the question of a gastric cancerous tumor; the points of distinction are the characteristic symptoms of gastric cancer, and that abdominal tumors, especially of the liver and spleen, the ones most apt to cause error in diagnosis, are influenced by inspiration, while *tumors of the stomach* are not so influenced.

When a scirrhus of the pylorus lies upon the aorta, a pulsation may be communicated to it, raising the question of *aneurism of the abdominal aorta*, but the expansile pulsation of aneurism (Corrigan's sign) is wanting, as are the other symptoms of the affection, and if the patient is made to rest upon his hands and feet, the stomachic tumor falls away from the aorta and pulsation ceases.

Mikuliez claims that, by the use of his *gastroscope*, regular rhythmical motions can be seen when the pylorus is not the seat of cancer, and that such movements are absent when it is the seat of cancer.

**Prognosis.** Unfavorable. Internal medication offers no hope, the patient usually succumbing from starvation.

Gastric carcinoma occurring under thirty years of age is rapidly fatal, not conforming to the usual symptoms as seen later in life; the characteristic cachexia is commonly absent and haematemesis is rare.

**Treatment.** We possess no means of arresting the disease. "Six operations have been practiced for the relief of stenosis of the pylorus: 1st. Pylorectomy; 2d. Gastro-enterostomy; 3d. Gastrectomy; 4th. Gastrostomy; 5th. Duodenostomy; 6th. Digital divulsion of the pylorus." Professor Billroth has *excised* the pylorus, thereby prolonging life ten months.

For acidity and fétor of the breath, *acidum carbolicum*, gr.  $\frac{1}{4}$ - $\frac{1}{3}$ , or *carbo animalis purificatus*, gr. x-xxx, affords some relief.

For vomiting, *bismuth* and *opium*, or the washing out of the stomach with the stomach pump.

For pain, *morphina*.

Avoid stimulants.

## GASTRIC DILATATION.

**Synonyms.** Pyloric obstruction ; pyloric stenosis.

**Definition.** An abnormal increase of the cavity of the stomach, with the walls either hypertrophied, or decreased in thickness ; characterized by pronounced indigestion, vomiting of partly digested and partly decomposed food at intervals of a day or two, and noisy moving of flatus in the abdomen (*borborygmus*).

**Causes.** Most common cause a stricture of the pylorus, the result of cancer ; pressure of tumor against the pylorus, preventing exit of stomachic contents. Loss of muscular tone, occurring in anaemia. Prof. Bartholow cites cases resulting in excessive beer-drinkers, who drank thirty to forty glasses of beer habitually, every day.

**Pathological Anatomy.** When obstruction exists at the pylorus, the whole organ is dilated, with hypertrophy of the muscular layer of the stomach. In dilatation without pyloric obstruction, the muscular layer is thinner than normal, paler in color, and presents signs of fatty degeneration ; the mucous membrane is also pale, thin, and without rugæ.

**Symptoms.** Those of the disease producing the obstruction *plus* those of obstinate chronic gastric catarrh, with *characteristic vomiting* ; the cavity having a greatly increased capacity, large accumulations take place, which are rejected every day or two, partly digested and partly decomposed. *Regurgitation* of partly digested aliment, acrid, acid and offensive, is very common. *Bowels constipated*, the stools hard and dry.

*Physical signs of gastric dilatation are : on inspection*, abnormal prominence of the whole epigastric region, with a tumor in the *pyloric region* which seems to be connected with the stomach ; *percussion*, if empty, tympanitic note extending to or below the umbilicus, having a metallic quality ; if the stomach be filled, high-pitched flat note ; *auscultation*, splashing and rumbling sound, the succussion sound being distinct if the body be shaken.

**Diagnosis.** Copious vomiting of food partly digested, once in twenty-four hours or less often, epigastric distress and pain resulting from foul smelling and acid eructations and from obstinate constipation.

Penzoldt's modification of Piorry's method of determining gastric dilatation is to withdraw the contents of the stomach by means of the œsophageal tube and then refilling the stomach with fluid. By noting

the lower limit of percussion dullness thus produced, the lower border of the stomach can be accurately determined.

**Treatment.** Regulated diet. Restrict the use of fluids, using a "dry diet" exclusively.

If the result of pyloric stenosis, one of the operations mentioned for pyloric cancer may be indicated.

Regardless of the cause, washing out the stomach with the stomach pump, every day or two, gives relief, and, if no stricture be present, administer *strychnina* or *nux vomica*, and very favorable results may follow.

## GASTRIC HEMORRHAGE.

**Synonyms.** Hæmatemesis ; gastrorrhagia.

**Definition.** Gastric hemorrhage is not, strictly speaking, a disease, but a *symptom*; still, vomiting of blood occurs under such a variety of conditions, that a separate consideration is desirable.

**Causes.** Ulcer of the stomach ; cancer of the stomach ; scurvy ; purpura ; hemorrhagic malarial fever ; congestion of the liver or spleen ; vicarious at menstrual period ; yellow fever.

**Symptoms.** Added to the symptoms of the cause of the hemorrhage, are a *feeling of faintness* and *sinking at the pit of the stomach*, followed by the ejection of blood of a *black, grumous, or coffee-ground* appearance. Rarely, and then generally in gastric ulcer, the ejected blood may have a *bright red* appearance, the gastric juice not having had time to act upon it. If the amount of blood escaping into the stomach is large, *blood will be voided by stool*.

**Diagnosis.** *Hemorrhage from the lungs* may be confounded with gastric hemorrhage. In the former, the blood is red, is coughed up, not vomited, and is associated with a history of pulmonary disease. The chief point of distinction between pulmonary hemorrhage and the vomiting of red blood is, that in the former you can discern râles on auscultating the chest, and they are absent in the latter.

**Prognosis.** Depends entirely upon the cause, the most unfavorable being the result of either gastric ulcer or cancer.

**Treatment.** Perfect rest in bed. *Ice*, internally and applied in bladders over the epigastrium and along the spine.

Hypodermic injections of *morphina* quiet the patient's fear, and at the same time have a constringing effect upon the vessels. *Extrac-*

*tum ergotæ fluidum* or *ergotin* hypodermically after the patient is quieted, or *liquor ferri subsulphatis*, gtt. j-v, well diluted by stomach.

Cases resulting from congestion of the liver or spleen are benefited by *saline purgatives*.

Allow no food by the stomach for several days, nourishing the patient by rectal alimentation.

The hemorrhage controlled, the future treatment is guided by the exciting cause.

### GASTRALGIA.

**Synonyms.** Cardialgia; gastrodynia; stomachic colic; spasm of the stomach; neuralgia of the stomach.

**Definition.** A painful condition of the sensory nerves of the stomach, induced by various sources of irritation; characterized by violent paroxysms of gastric pain and spasm, associated with feeble cardiac action, and symptoms of collapse.

**Causes.** The affection belongs to the group of neuralgiæ. The most important factor in its causation is general nervous depression; other causes are malaria, rheumatic or gouty diathesis, anæmia, and certain articles of diet.

**Symptoms.** Like most neuroses, gastralgie is distinguished by its *paroxysmal* character. *Romberg* thus describes an attack:—

“Suddenly, or after a feeling of pressure at the præcordium, there is severe *gripping pain* in the stomach, usually extending to the back, with a *feeling of faintness*, a shrunken countenance, cold hands and feet, and an *intermittent pulse*. The *pain* becomes so excessive that the patient cries out. The *epigastrium* is either *puffed out*, like a ball, or *retracted*, with tension of the abdominal walls. There is often *pulsation in the epigastrium*. External pressure is well borne, and not unfrequently the patient presses the pit of the stomach against some firm substance, or compresses it with his hands. *Sympathetic pains* often occur in the thorax, under the sternum, and in the cesophageal branches of the pneumogastric, while they are rare in the exterior of the body.”

“The attack lasts from a few minutes to half an hour or longer; then the pain gradually subsides, leaving the patient much exhausted; or else it ceases suddenly, with eructation of gas or watery fluid, or with vomiting, and with a gentle, soft perspiration, or with the passage of reddish urine.”

Besides such severe attacks, we often see *painful sensations in the epigastrium*, of various degrees of intensity, with passing faintness or sinking at the "pit of the stomach."

**Diagnosis.** From *myalgia of the abdominal muscles*, by the pain of gastralgia being more acute and lancinating, accompanied by nausea and vomiting and the absence of tenderness on pressure.

From *intercostal neuralgia*, by the fact that in this affection the pain is in the left hypochondrium, with painful spots along the course of the nerve trunk and at the spine, and absence of nausea and vomiting.

From *gastric cancer*, by the age, character of the vomited matter, constancy of the pain, the cachexia, emaciation and the tumor.

From *gastric ulcer*, by the localized pain and its constancy, with tenderness and vomiting of blood, and constant dyspeptic symptoms, which is not the case in gastralgia.

**Prognosis.** As to perfect recovery, unfavorable, but not dangerous to life. A chronic affection, in that attacks are prone to return from time to time. The cause has much to influence a radical cure.

**Treatment.** For the *paroxysm*, hypodermic injections of *morphina*, gr.  $\frac{1}{2}$ - $\frac{1}{4}$ , or the stomachic administration of the "compound of anodynes," the so-called *chlorodyne*, in doses of  $\text{m}_x\text{-xxx}$  p. r. n. The relief afforded by opium in some form is so decided that it is prone to lead to the opium habit when the attacks are frequent.

In the interval, regulated diet and one or more of the following remedies: *quinina*, *arsenicum*, *bismuth*, *ferrum*, *liq. iodi. comp.*, or small doses of *potassii iodidum*.

## ATONIC DYSPEPSIA.

**Synonyms.** Dyspepsia; indigestion; heartburn; pyrosis.

**Definition.** A functional derangement of the stomach, with either deficient secretion in the *quantity* or *quality* of the gastric juice; characterized by disorders of the functions of digestion and assimilation and the presence of sympathetic nervous symptoms.

**Causes.** Imperfect mastication; bolting of food; eating large quantities of food; same diet long continued; depressed nervous system, from worry and fatigue; sedentary habits or occupations. It is often inherited.

**Symptoms.** *Perverted appetite*, capricious or lost; *difficult digestion*, a feeling of weight or fullness in the epigastrium; *acidity*, from the decomposition of albuminoids; *heartburn*, *flatulency*, *regurgitation*, or *vomiting* of portions of partly digested food or acrid fluid—*water brash* or *pyrosis*. *Pain* or *soreness* at the “pit of stomach” during digestion. *Tongue* either clean or broad, flabby and pale, showing marks of the teeth. *Bowels* constipated; *urine* generally scanty and high-colored, with excess of urates or oxalates, or, in persons of nervous type, it is pale, of low *specific gravity*, and contains phosphates. *Drowsiness* after meals, with *wakefulness* at night, *defective memory*, *headache* and *absent mental vigor*, with *flashes of heat*, followed by more or less perspiration. *Palpitation* of the heart with *irregularity in rhythm*.

*Varieties of Dyspepsia.*—I. *Nervous dyspepsia*, atonic form, seen in active business or busy professional men, especially those of thin, spare build of nervous temperament, who eat meals rapidly and hurry off to their business. These cases present all the marked nervous phenomena. II. *Flatulent dyspepsia*, seen in hysterical individuals, and showing immense development of gas throughout abdomen, and nervous symptoms. III. *Acid dyspepsia*, water-brash. Seen when the diet is coarse. Acidity of the gastro-intestinal canal and of the urine. IV. *Irritative dyspepsia*. Vomiting a prominent symptom. In these cases the tongue is small, red and pointed.

**Prognosis.** With careful living, dyspepsia, functional in character, is curable. It has been aptly termed “remorse of the stomach.”

**Treatment.** The most important indication is to regulate the diet. *Forbid saccharine, starchy, or fatty articles of food.* Eat small amounts at a time. Perfect insalivation and mastication. *Rest after eating*, from a half to an hour. Allow but small quantities of liquids with the meals. In the vast majority of cases *forbid the use of stimulants with the meals*.

Aid digestion with *pepsinum*, with or without *acidum hydrochloricum dilutum*.

Stimulate stomachic peristalsis with *nux vomica*, *gentian* or *cinchona*.

For acidity, alkalies at time of acidity.

For flatulency, *carbo animalis purificatus*, gr. x-xx, or one or more of the carminatives, with *tinctura nucis vomica* before meals.

For pyrosis, *bismuth* and *pulvis aromaticus*, in large doses.

For *vomiting*, *sodii bromidum* in small doses, or *acidum carbolicum*, gr.  $\frac{1}{6}$ - $\frac{1}{4}$ , three or four times daily.

For *constipation*, *resina podophyllum*, at bedtime.

For *anæmia*, *massa ferri carbonatis* or *ferri lactas*.

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## DISEASES OF THE INTESTINAL CANAL.

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### INTESTINAL INDIGESTION.

**Synonym.** Intestinal dyspepsia.

**Definition.** A derangement in the functions of intestinal digestion, resulting in the more or less complete decomposition of the *chyme*, from defects in the pancreatic, biliary or intestinal secretions, or from deficient peristalsis, one or more, singly or combined; characterized by abdominal pain, distention, tympanites some hours after meals and nervous perturbation, anaemia and emaciation.

**Causes.** Imperfect diet; over eating; anaemia; deficient exercise; worry; immoderate use of tobacco; diseases of the intestinal tract, liver or pancreas; malaria. Frequently inherited.

**Symptoms.** Intestinal indigestion may be either *acute* or *chronic*, the latter the more common.

*Acute variety*, the result of an irritant in the duodenum; rapidly developed pain, flatulency, borborygmi, slight feverishness, coated tongue, loss of appetite, headache, pains in the limbs, usually terminating in a mild attack of diarrhoea.

If the attack develops rapidly, the sudden formation of gases results in a paroxysm of *colic*.

Severe attacks are associated with disordered hepatic function, to wit: light-colored stools, slight jaundice and high-colored urine.

*Chronic variety*, resulting from a greater or less decomposition of the partly altered food from the stomach. Pain, varying in character, occurring from two to four or six hours after meals, with slight tenderness and some fullness in the right hypochondrium, epigastrium or the umbilical region. Tympanites and borborygmi are marked, the result of gaseous accumulations which have resulted

from the decomposition of the intestinal contents. *Dyspnœa*, the result of pressure against the diaphragm, is of frequent occurrence. Marked nervous phenomena develop, the result of the anaemia from deficient assimilation and from the depressing influence on the nervous system of the absorption of the "gases of decomposition;" *depression of spirits, hypochondriasis, sleeplessness, disturbing dreams, headache, vertigo, buzzing in the ears, muscæ volitantes, deficient mental application, cardiac irritability, numbness and tingling in the extremities, anomalous pains throughout the body*, and in marked cases, attacks of *fainting, epileptiform and cataleptic attacks*.

The skin is harsh and dry, the *bowels* are sluggish or *constipated*, the *urine* is high colored, of increased density, decidedly acid, and on cooling deposits lithates, uric acid and oxalate of lime crystals.

Functional derangement of the liver follows after a time, adding to the general distress.

*Anæmia* and *emaciation* result if the attack be protracted.

**Diagnosis.** With our present knowledge it is usually impossible to designate forms of intestinal indigestion due to defects in the quantity or quality of either the pancreatic, biliary or intestinal secretions.

*Acute intestinal indigestion* differs from gastric indigestion in the time of development of the various phenomena, in the latter the symptoms appearing almost immediately after meals, while in the former not appearing until two, four or six hours after.

*Chronic intestinal indigestion* may mislead the physician if the various nervous phenomena are of a marked character, and a careful history of the case is not developed.

**Prognosis.** Favorable if proper and early treatment is inaugurated, unless the result of an organic lesion.

**Treatment.** *Acute variety*, the result of indigested food, is best treated by *opium* in some form, to relieve the acute suffering, warmth to the abdomen, and a prompt cathartic to cause its rapid expulsion.

*Chronic variety.* Of the first importance is the diet, which should be restricted in amount and confined almost entirely to such articles as are readily digested in the stomach, such as beef, eggs and milk.

The hepatic, pancreatic and intestinal secretions should be stimulated by a course of *alkalies*, one of the most efficient being *sodii phosphas, ʒj-ij*, three times a day.

Aid intestinal digestion by the administration of the *liquor pancre-*

aticus, fʒ j-iv, of the *extractum pancreatis*, gr. ij-vj, with *sodii bicarbonatis*, gr. v-x, two or three hours after meals.

For constipation, bitter waters, such as Friedrichshall, Pullna, or Hunyadi János, or *resina podophyllum*, at bedtime.

### INTESTINAL COLIC.

**Synonyms.** Enteralgia; tormina; gripes.

**Definition.** A spasmodic contraction of the muscular layer of the intestinal tube; characterized by acute paroxysmal pain near the umbilicus, relieved by pressure, and associated with feeble cardiac action.

**Causes.** Constipation; presence of indigestible food; collections of flatus; an abnormal amount of bile discharged into the intestines; lead poisoning; syphilis; chronic malaria; rheumatism; hysteria.

**Symptoms.** Romberg thus describes a paroxysm: "There are attacks of *pain*, spreading from the navel over the abdomen, alternating with intervals of ease. The pain is *tearing*, *cutting*, *pressing*, most frequently *twitching*, *pinching*, accompanied by peculiar *bearing-down pains*. The patient is restless, and seeks *relief* in changing his position and in *compressing the abdomen*; his surface may be cold and his features pinched. The *pulse* is *small and hard*. The abdomen is tense, whether puffed up or drawn inward. There are often *nausea* and *vomiting*, and *desire for stool*. There is usually constipation, but sometimes the bowels are regular or even too loose. Duration from a few minutes to several hours, relaxing at intervals. The attack ceases suddenly, with a feeling of the greatest relief, although some soreness remains for a few days."

*Lead colic* is always preceded by symptoms of lead poisoning, to wit: slate-colored skin, dark gums, showing blue line, heavy breath, with sweetish metallic taste, obstinate constipation, impaired appetite, slow pulse and contracted abdominal walls.

**Diagnosis.** *Gastralgia* differs from colic, in the pain being in the epigastric region and associated with disorders of digestion.

In *hepatic colic*, or the passage of gall stones, the pain is in the hepatic region, attended with soreness over the gall bladder, and retching and vomiting, followed by jaundice and the presence of bile in the urine.

In *nephritic colic* the pain follows the course of one or both ureters,

shooting to loins and thigh, with retraction of the testicle of the affected side, strangury and bloody urine.

In *uterine colic* the pain is in the pelvis, and associated with menstrual disorders, in fact, a dysmenorrhœa.

In *ovarian colic* or neuralgia, pain on pressure over the ovaries, with hysterical phenomena.

*Inflammatory disorders of the abdomen* differ from colic by the presence of fever and tenderness on pressure.

**Prognosis.** Most favorable. Death is the rarest termination possible.

**Treatment.** Relief of pain is the first indication, and is best accomplished by a hypodermic injection of *morphina*, gr.  $\frac{1}{6}$ - $\frac{1}{3}$  which has the additional advantage of relaxing the spasm, thereby favoring the action of purgatives, which should soon follow. One of the best in colic, no matter from what cause, is *massæ hydrargyrum*, gr. v-x, or *hydrargyri chloridum mite*, gr.  $\frac{1}{2}$  every half hour until four or five grains are taken, followed by a mild saline cathartic.

After the relief of the pain and free action of the bowels, the cause of the attack should be ascertained and corrected, to prevent future suffering.

For *lead colic*, *morphina*, for the pain; *oleum ricini* or *magnesii sulphas*, 3j, every hour for the constipation, and *potassi iodidum*, gr. v-x, after meals, to eliminate the metal from the system.

## CONSTIPATION.

**Synonyms.** Intestinal torpor; costiveness.

**Definition.** A functional inactivity of the intestinal canal, either due to atony of the muscular coat, causing lessened peristalsis, or to a deficiency of intestinal and biliary secretion; characterized by a change in the character, frequency and quantity of the stools.

**Causes.** Dyspepsia; character of the food; habits of the patient; diseases of the stomach and liver; malaria; lead poisoning; syphilis.

**Symptoms.** In the normal condition the majority of persons have one stool each day, although it is not to be considered abnormal if more or less than that number occur.

The *bowels* are moved every three or four days, with great straining and distress, the face often flushed, the cerebral vessels full.

Or in other cases the bowels may be relieved once a day, but the stool is small and hard, causing great pain.

Another group of cases have frequent stools during the day, small and non-formed, due to retained hardened faeces acting as an irritant upon the rectum.

The change in the character of the stools is soon followed by symptoms of dyspepsia, headache, mental torpor, vertigo, palpitation on exertion, and in many cases with great distention of the abdomen.

**Prognosis.** Death never results from functional constipation.

**Treatment.** The successful treatment depends upon the removal of the cause and the hearty co-operation of the patient.

First, the patient must have a regular hour each day for going to stool, and must remain a sufficient time to permit a thorough evacuation of the bowels.

Second, the diet must be carefully regulated.

Third, purgative mineral waters or cathartic medicines are to be used with caution, their reckless administration often doing more harm than good.

Fourth, either of the following formulæ, aided by the enforcement of the above rules, will give good results:—

R.	Ext. nucis vomicæ,	gr.	$\frac{1}{4}$
	Ext. belladonnæ alco.,	gr.	$\frac{1}{4}$
	Extract aloes aqua,	gr.	ss
	Pulv. rhei,	gr.	j
	Olei cajuputi,	gtt.	j.

In pill, at bedtime, and after a week, every second or third night.

R.	Resinæ podophyl.,		
	Ext. physostig.,		
	Ext. belladonnæ alco.,		
	Aloine,	aa	gr. $\frac{1}{4}$ .

In pill, every night, or second or third night.

R.	Ext. cascaræ sagradæ, fld.,	m	xxx
	Glycerini,	m	x
	Syr. sarsaparillæ,	m	xx.

Hour after meals, or once a day as indicated.

Success often follows an enema of glycerini 3 j-iv, or a suppository of glycerinum.

*Electricity* to the abdomen is worthy a trial; one pole over abdomen the other at anus; using either galvanism or faradism.

## DIARRHŒA.

**Synonyms.** Enterorrhœa; alvine flux; purging.

**Definition.** Frequent loose alvine evacuations, without tenesmus; due to functional or organic derangement of the small intestines, produced by causes acting either locally or constitutionally.

**Causes.** Those acting locally, such as *indigestion, indigestible food, impure food and water, irritating matters or secretions* poured into the bowels, or *entozoa*, cause the flux by a direct irritation of the mucous surface.

Attacks of diarrhœa due to constitutional derangement may be secondary to such diseases as *tuberculosis, pyæmia, albuminuria, typhoid fever*, or disturbances of the functions of other organs, giving rise to *vicarious fluxes*.

Atmospheric changes as well as a sudden mental shock will predispose to an attack of diarrhœa.

**Forms.** Acute and chronic.

**Symptoms.** Acute diarrhœa presents itself in several varieties, the result of its particular cause, to wit:—

*Feculent diarrhœa.* A few hours after meals the patient feels *colicky pains and flatulency*, with a *desire for stool*. There is often *nausea, coated tongue*, but seldom vomiting. The *pain* is generally relieved by the purging which ensues. The *stools* have a *feculent character*, are of brown fluid, containing *fæces*, often offensive, the color becoming lighter after four or five evacuations. Constitutional symptoms are wanting.

This form is the result of over eating, eating too rapidly, or indigestion of different forms, or worms in the intestinal canal, and patients generally recover in a day or two.

*Lienteric diarrhœa.* In this form there is, with the frequency of evacuations, a *want of assimilation of food*, which passes through the intestines more or less unaltered. The *stools* are frequent, *mucous or serous*, more or less *covered with bile*, mixed with *undigested food*. In this form the patients emaciate rapidly, owing to the deficient assimilation, the digested portions of the food being hurried on by the increased peristalsis of the irritated bowel. It is usually subacute in its course.

*Bilious diarrhœa.* The *stools* are frequent, *green or yellow*, with *scalding sensations at the anus and griping pains in the abdomen*. Excessive biliary secretion is the irritating cause.

Any of the above forms may pass into chronic diarrhoea by exciting permanent diseases of the intestines. Diarrhoea due to constitutional causes will be mentioned when speaking of those conditions.

*Chronic diarrhoea* results from repeated attacks of the acute form, or is the result of some cachexia. The *symptoms*, as far as the stools are concerned, are much the same as the acute disease, except they are *paler*, whence it has been termed *white flux*; in addition, *dyspeptic symptoms*, *aphthous* condition of the mouth and tongue, *flatulency*, *colic*, *emaciation* and *anaemia*. The appetite is at times capricious, again impaired.

**Prognosis.** Favorable in *feculent* and *bilious* forms; unfavorable in *lienteric* and *chronic* forms when emaciation begins. Diarrhoea occurring as a symptom, the prognosis is controlled by the original disease.

**Treatment.** *Acute diarrhoea.* If caused by indigestion the *indication* is for a *laxative*; for adults, *tinct. rhei*, or *ol. ricini*, or both; for children between one and two years of age—

R. Pulv. ipecac,	gr. $\frac{1}{2}$	M.
Pulv. rhei,	gr. $\frac{1}{4}-\frac{1}{3}$	
Sodii bicarb.,	gr. ss-ij.	

Every four hours until the character of the stools change.

After the irritant is removed, for an adult, *opium* in some form, combined with *kino* or *tannin*; or the following modification of "Squibb's diarrhoea mixture":—

R. Tinct. opii deodorat.,	fʒ viss	
Tinct. camphoræ,	fʒ j	
Tinct. capsici,	fʒ v	
Chloroformi puræ,	fʒ iiss	
Sots. vini gallici,	fʒ j	
Alcoholis, . . . . . ad	fʒ iv.	M.

SIG.—One teaspoonful, p. r. n.

For children—

R. Bismuth,	gr. iiij-v	
Cretæ præp.,	gr. v.	M.
Every two hours.		

In adults, an *opium* suppository often checks a flux that is uninfluenced by opium internally.

For the *bilious* form—

R. Hydrarygi chlor. mitis, . . . . . gr.  $\frac{1}{8}$   
 Sodii bicarb., . . . . . gr. ij  
 Pulv. opii, . . . . . gr.  $\frac{1}{4}$ . M.

In powder, every two or three hours, until eight powders are used, followed by large doses of *bismuth* and *pepsinum*.

In all acute forms *restricted* and *regulated* diet are imperative, *pure milk* with *liquor calcis* being the most suitable.

*Chronic diarrhœa.* *Bismuth*, gr. xxx-xl, in milk, every four hours; *Hope's camphor mixture*, every four hours; *cupri sulphas*, gr.  $\frac{1}{2}$ , *ext. opii*, gr.  $\frac{1}{2}$ , every four hours; *argenti nitras*, gr.  $\frac{1}{2}$ , *ext. opii*, gr.  $\frac{1}{2}$ , every five hours; may all be used with more or less success; when *dry tongue* and *great flatulency*, use—

R. Ol. terebinthini, . . . . . f $\frac{3}{2}$ j  
 Ol. amygdal. express., . . . . . f $\frac{3}{2}$ ss  
 Tinct. opii, . . . . . f $\frac{3}{2}$ ij  
 Mucil. acaciæ, . . . . . f $\frac{3}{2}$ v  
 Aq. lauro-cerasi, . . . . . f $\frac{3}{2}$ ss. M.

SIG.—f $\frac{3}{2}$ j every three or four hours.

The diet should be nutritious in character, and moderate stimulants are indicated. Activity of the skin and kidneys should be encouraged.

### CATARRHAL ENTERITIS.

**Synonyms.** Ileo-colitis; acute diarrhoea; inflammation of the bowels.

**Definition.** A catarrhal inflammation of the mucous membrane of the small intestines; characterized by fever, pain, tenderness and looseness of the bowels. When the catarrh is limited to the duodenum, it is termed *duodenitis*.

**Pathological Anatomy.** There first ensues *hyperæmia* of the mucous membrane and intestinal glands, manifested by *redness*, *swelling* and *œdema*; this is followed by *increased secretion* and an *overgrowth* and *desquamation* of the epithelium, together with a *copious generation of young cells*. As a result of the hyperæmia, rupture of the capillaries and extravasation of blood often occur.

The swollen glands show a strong tendency to ulcerate. This catarrhal process may involve the entire tube or be limited to portions of it.

**Causes.** Improper and indigestible food; summer temperature and exposure to cold and wet, while perspiring.

**Symptoms.** Begins with *languor*, followed by *chilliness* and *fever*, the temperature ranging at  $102^{\circ}$ - $103^{\circ}$ , this is followed by *pain*, colicky and paroxysmal in character, situated above the umbilicus, localized tenderness and *loose evacuations*. *Nausea* and *vomiting* often occur. The *stools* contain but *little fecal matter*, are *yellow* or *greenish-yellow* in color, mixed with *undigested food*; if the stools are numerous, they become whitish and watery, the so-called "*rice-water*" discharges. The appetite is impaired, and this, with the want of assimilation and great waste, soon produce extreme *weakness* and *emaciation*, which is always more marked in children.

**Duration.** In mild cases, four or five days; severe cases continue more or less marked, for a week or two.

**Diagnosis.** From *colic*, by the absence of tenderness and fever, and presence of constipation and its paroxysmal character.

From *typhoid fever*, by the absence of prodromes, characteristic temperature record and eruption.

For points of distinction from *dysentery* or *peritonitis*, see those affections.

**Prognosis.** Favorable, if early and proper treatment are observed.

**Treatment.** *Rest the bowels* by a restricted diet, such as milk and lime water, or weak mutton or chicken soups, with well boiled rice added.

*Keep the patient quiet in bed*, a difficult matter in the case of children.

For adults, *opium* is the remedy, in doses to control the symptoms; mild cases do well with—

R. Ext. opii, . . . . .	gr. $\frac{1}{4}$ - $\frac{1}{2}$	M.
Camphoræ, . . . . .	gr. iiij.	

In pill, every three hours.

Or—

R. Tinct. opii deodorat., . . . . .	gtt. x	
Liq. potassii citrat., . . . . .	3 ij.	M.

Every four hours.

The strength and the frequency of administration of either of these formulæ must be governed by the severity of the attack.

For *children*—

R. Tinct. opii deodorat., . . . . . gtt. j  
 Bismuth. subnit., . . . . . gr. v  
 Mist. cretæ, . . . . . fʒj. M.

Every four hours, for a child of one year.

If the case shows the least tendency to linger, the *acid* treatment should be substituted for the above, the best of which is "Hope's Camphor Mixture," the formula being—

R. Acidi nitrosi, . . . . . fʒj  
 Tinct. opii, . . . . . gtt. xl  
 Aquæ camphoræ, . . . . . fʒ viij. M.

The dose ranging from fʒj to fʒ viij, according to the age.

*Acidum sulphuricum dilutum* may be substituted for the acidum nitrosum in the above formula.

Locally, poultices, warm fomentations, or *ung. belladonnae* or *oleum camphoratae*, give great relief.

### CROUPOUS ENTERITIS.

**Synonym.** Membranous enteritis.

**Definition.** A croupous inflammation of the mucous membrane of the small intestines; characterized by tenderness, paroxysmal pain, moderate fever, and the formation and discharge of membranous shreds or casts.

**Causes.** A disease of adult life. The female sex more liable than the male, and neuralgic, nervous, hysterical or hypochondriacal subjects are more subject to it than are other types.

A peculiar state of the nervous system seems necessary to its production.

**Pathological Anatomy.** A subacute inflammation of the small intestines, during which the mucous membrane becomes covered with a whitish or grayish-white, firmly adherent, membranous deposit, cemented together by a coagulable exudation, and prolonged by rootlets from its under surface into the intestinal follicles.

**Symptoms.** Begins by *feverishness*, feeling of *soreness* and *distention* of the abdomen; these are followed by *pains* of a colicky character, severe and depressing, felt around the *umbilicus*, continuing for half an hour, an hour or longer, and after a longer or shorter interval occurring again; these phenomena continue for a day or two, when

*looseness of the bowels*, with distressing *pain* and *tenesmus* occur, the stools containing mucus, with or without blood, and shreds of membrane or cylindrical casts of the bowel. Great relief is then experienced, although a feeling of rawness or soreness persists for a day or two.

Preceding the local manifestations of the disease are attacks of hysteria, hypochondriasis, neuralgia, nervousness or excitability.

The paroxysms recur at intervals of a week or two, or after several months; as long an interval as three years between attacks is recorded.

**Diagnosis.** *Peritonitis* may be suspected until the characteristic stools occur.

*Dysentery* is excluded when the shreds and casts of membrane appear.

**Prognosis.** Favorable as to life, but one of the most difficult of diseases to eradicate.

**Treatment.** The *diet* must be such as contains but a minimum of fecal-forming matter.

For the *pain* and *suffering*, *opium* in some form is indicated, the most effective being a hypodermic injection of *morphina*.

For *constipation* during a paroxysm, an emulsion of *oleum ricini* and *terebinthina* is of benefit. To prevent a return of the paroxysms either *liq. potassii arsenitis*, gtt. j-ij, before meals, or *hydrargyri chloridum corrosivum*, gr.  $\frac{1}{60}$ , three times a day, with a course of *oleum morrhua*, seems to answer in the majority of cases. Prof. Da Costa speaks highly of *pix liquida* in some form, as an alterative to the mucous membrane.

Under no circumstances must the bowels become constipated.

## CHOLERA MORBUS.

**Synonyms.** Sporadic cholera; English cholera; biliary cholera.

**Definition.** An acute catarrhal inflammation of the mucous membrane of the stomach and intestines, of sudden onset; characterized by violent abdominal pains, incessant vomiting and purging, cold surface, rapid, feeble pulse, spasmodic contractions of the muscles of the abdomen and extremities, and prostration.

**Causes.** A disease of summer and early autumn, climatic influence being an important factor. Irritants of all kinds, unripe fruits and vegetables, and fermentation of food.

**Pathological Anatomy.** Cases in which death has occurred within a few hours present no pathological changes.

Generally, however, the gastro-intestinal mucous membrane is congested and denuded of epithelium ; the Solitary and Peyerian glands are swollen and prominent. The blood is thick, and dark in color ; the kidneys are enlarged and congested ; and in prolonged cases there are appearances of granular changes in the muscular system.

**Symptoms.** Onset sudden and violent, and unfortunately, generally after midnight, with chilliness, intense nausea, vomiting and purging, accompanied with distressing burning or tearing abdominal pains or colic. The vomited matter at first consists of the ordinary contents of the stomach, and the stools of ordinary fæces, but soon the discharges by vomit and stool are liquid, whitish or of a green or yellowish tint ; if the attack is severe or protracted the discharges partake of the "rice-water" character. The patient is rapidly emaciated and reduced in strength, the body shrinks, the surface cold and covered with a clammy sweat, and the pulse feeble. Intense thirst is present, and when drink is given it is at once rejected.

Aggravating the distress of the patient are severe cramps of the muscles, and especially those of the calves, and of the flexors of the thighs, forearms, fingers and toes.

**Termination.** Mild cases often terminate favorably without treatment, the patient able to be around in a day or two, although weak.

Severe cases, the vomiting and purging cease after some hours, but the patient remains weak, with an irritable stomach and bowels for a week or two.

Grave cases, the true cholera type, recover from the prostration very gradually ; reaction coming on slowly and usually passes into a typhoid condition of some weeks' duration.

**Diagnosis.** Asiatic cholera and cholera morbus are easily confounded during an epidemic of the former, and there are no positive points of discrimination, unless the *comma bacilli* of Koch are proven to be always in the true cholera stools.

*Irritant poisons*, such as tartar emetic, elaterium, or other substances, cause vomiting and purging, similar to cholera morbus, and are only discriminated from it by the history.

**Prognosis.** In the majority of cases favorable. The mortality is about five per cent.

**Treatment.** At once, regardless of the cause, a hypodermic injection of *morphinæ sulph.*, gr.  $\frac{1}{8}$ - $\frac{1}{3}$ , and *atropinæ sulph.*, gr.  $\frac{1}{120}$ , to be repeated in half an hour if no improvement; for patients who object to the hypodermic mode, *opium* in some form by the mouth or rectum, giving the preference to the liquid preparations.

*Camphora* and *opium* combined often act well, or the diarrhoea mixture mentioned on page 78, and if much depression, small doses of *brandy* or *dry champagne*.

The intense thirst must not be gratified by the use of liquids, but small pellets of ice by the stomach are grateful.

If the vomiting and purging continue, make use of—

R.	Bismuth subnit., . . . . .	gr. xx
	Acid caibol., . . . . .	gr. $\frac{1}{6}$
	Glycerini, . . . . .	gtt. xx
	Aquæ, . . . . . ad	fʒ iv. M.

Every hour or two.

Dr. Hartshorne strongly recommends—

R.	Spts. ammon. aromat., . . . . .	fʒj
	Magnes. optim., . . . . .	fʒj
	Aq. menth. pip., . . . . .	fʒ iv. M.

SIG.—ʒj every twenty minutes.

If the case is seen early, and if the diarrhoea is copious, he adds *tinct. opii camph.*, fʒ iv, to the mixture.

The closer the case approaches the true cholera type, the more severe are the muscular cramps, and their treatment is indicated. Prof. Da Costa suggests—

R.	Chloral, . . . . .	ʒ iv
	Cosmoline, . . . . .	ʒ j. M.

To be rubbed over the affected muscles.

Dr. Bartholow suggests—

R.	Chloral, . . . . .	ʒ iij
	Morphinæ sulph., . . . . .	gr. iv
	Aquæ, . . . . .	fʒ j. M.

SIG.—Twenty minims, hypodermically.

Locally, *sinapis* in the form of poultices or the dry powder, should be applied from the onset.

The after treatment depends upon the symptoms; generally an acid mixture and a regulated diet, with tonic doses of *quinina*, are indicated.

## ENTERO-COLITIS.

**Synonym.** Inflammatory diarrhoea.

**Definition.** A catarrhal inflammation of the lower portion of the small—ilium—and the upper portion of the large intestines, with a great tendency to ulceration of the intestinal glands if the catarrh becomes chronic ; characterized by moderate fever, nausea, vomiting, diarrhoea, swollen abdomen, pain and emaciation.

**Causes.** Improper and indigestible food ; summer temperature ; impure air ; uncleanliness ; exposure to cold and damp air.

**Forms.** Acute and chronic.

**Pathological Anatomy.** *Acute variety* ; hyperæmia, swelling, œdema and softening of the mucous membrane of the lower portion of the small and the upper portion of the large intestines, with hyperplasia of the intestinal follicles, their excretory follicles enlarged and tumid, readily distinguished as grayish or blackish points in the middle of the glands ; the patches of Peyer are also enlarged, tumefied and project above the level of the surrounding mucous membrane, the orifices of the follicles appearing as dark points ; these patches often have an ulcerated appearance, but upon close examination such is found not to be the case.

*Chronic variety* ; the thickening and infiltration have extended to the submucous and muscular coats, followed by induration of the tissues, so that the walls of the intestines are often abnormally rigid. Ulceration occurs, which extends through the entire thickness of the membrane. "These ulcers, when isolated, are from one to one and a half lines in diameter, oval or circular in shape, and either have sharp-cut edges, as though the piece of mucous membrane had been cut out with a punch, or the mucous membrane bounding them is undermined." The small ulcers often coalesce, so that large, irregular ulcerated patches are formed, having for their base the submucous or muscular coats, and have a grayish-white color.

The mesenteric glands are enlarged, but seldom, if ever, undergo ulceration.

**Symptoms.** *Acute form* ; may develop slowly, with restlessness and fretfulness, or suddenly with *feverishness, loss of appetite, thirst, nausea, moderate vomiting, abdominal pain* ; or *diarrhœa* may be the first indication of illness on the part of the child. Regardless of the character of the onset, the *stools* soon present the characteristic appearance ; they are *semi-fluid, heterogeneous, greenish, acid, mixed with*

*yellowish fragments of ordinary faeces, and undigested casein, termed the "chopped spinach" stools.* The abdomen is enlarged and tender.

*Emaciation* is marked in proportion to the severity of the symptoms; in marked cases the child is reduced to a condition of the greatest debility within a very few days.

*Chronic form*; usually follows the acute form, the character of the symptoms being less severe, but decidedly persistent, the strength fails, the temper is very irritable, the complexion grows dark, sallow and unhealthy, the skin dry and harsh, and in consequence of the marked emaciation, either hangs in folds around the shrunken limbs, or is drawn tightly over the joints; the abdomen is enlarged and tender, the stools numbering from six to a dozen during the day and night, consisting of the products of an imperfect digestion mixed with mucus, serum, pus, and oftentimes blood, having a semi-fluid consistency, and an extremely offensive odor.

*Duration.* *Acute*, from ten days to about two weeks, subsiding gradually; *chronic*, from one to two or three months, or even longer.

*Diagnosis.* The acute form can hardly be mistaken for any other condition, if the characteristic stools and other abdominal symptoms are present. The chronic form has been frequently mistaken for diarrhoea of tuberculosis, an error that can hardly occur if a physical examination of the chest has been made.

*Prognosis.* Always a very serious malady, and proves fatal if it attacks the weak during midsummer, or when surrounded by unfavorable hygienic conditions; in vigorous children, who have passed through their first dentition, the prognosis is quite favorable.

*Treatment.* For the *acute form*, restricting the amount of food for the first few days is of importance. Fresh, pure air, cleanliness and rest are also of great importance.

Any one of the following formulæ may be used with advantage:—

R.	Calcii carbon. precip., . . . . .	ʒj
	Tinct. opii camph., . . . . .	fʒ ss
	Tinct. lavendulæ comp., . . . . .	fʒ ij
	Syr. gallæ aromat., . . . . .	fʒ iss
	Syr. acaciæ, . . . . .	fʒ j.

M.

SIG.—Teaspoonful, repeated every hour or two.

Or—

R.	Tinct. opii camph., . . . . .	fʒ ij
	Tinct. catechu comp., . . . . .	fʒ iv
	Misturæ cretæ, . . . . .	fʒ ix.

M

SIG.—One or two teaspoonfuls, every hour or two.

Or—

R.	Bismuth subnit., . . . . .	3 iv
	Pulv. acaciæ,	
	Sacc. alb., . . . . .	äa . . . . . q. s.
	Syr. gallæ aromat., . . . . .	fʒ ij
	Spts. vini gallici, . . . . .	fʒ ij
	Aquæ, . . . . . ad	fʒ iiij.

M.

SIG.—One or two teaspoonsfuls, every two hours.

Or—

R.	Pulv. ipecac., . . . . .	gr. ¼
	Bismuth subnit., . . . . .	gr. v
	Cretæ præp., . . . . .	gr. iiij.

M.

SIG.—Aster each stool.

Many cases do well with *pulvis kino comp.*, others with minute doses, frequently repeated, of *acidum lacticum*.

Locally, warmth to the abdomen, with mustard, turpentine stypes or the spice poultice, made as follows: cloves, allspice, cinnamon and anise seeds, each half an ounce, pounded (not powdered) in a mortar, and placed between two pieces of coarse flannel about six inches square and quilted in; soak this for a few minutes in hot brandy or hot whisky and water, equal parts, and apply to the abdomen, heating again as it becomes cool.

For chronic form; carefully regulated diet, rest and fresh air, and one of the following formulæ:—

R.	Acidi carbolici, . . . . .	gr. $\frac{1}{2}$ - $\frac{1}{8}$
	Tincturæ iodi, . . . . .	gtt. j-ij
	Aquæ menthe, . . . . .	3j.

M.

SIG.—Every three or four hours.

Or—

R.	Tinct. calumbæ, . . . . .	fʒ iiij
	Liq. ferri nitratis, . . . . .	m̄ xxvij
	Syrupi zingib., . . . . .	fʒ iiij.

M.

SIG.—One or two teaspoonsfuls, according to age, every three or four hours.

### CHOLERA INFANTUM.

**Synonyms.** Choleriform diarrhoea; summer complaint.

**Definition.** An acute catarrhal inflammation of the mucous membrane of the stomach and intestines, together with an irritation of the sympathetic nervous system, occurring in children during their first dentition; characterized by severe colicky pains, vomiting, purging, febrile reaction and prostration.

**Cause.** Age; bad hygiene, or as it is now entitled, "civic malaria;" continuous high temperature; improper food; dentition; constitutional as in the feeble, delicate, nervous or irritable.

**Pathological Anatomy.** Resembles closely, if not identical with, the phenomena of catarrhal gastritis and enteritis, together with a powerful irritation of the fibres of the sympathetic system.

**Symptoms.** The onset is sudden in a child previously well, or in a child suffering from a bowel affection.

Begins with *vomiting*, *purgings*, abdominal *pain*, *fever*, *rapid pulse* and *intense thirst*.

The *vomited matter* is partly digested food, sero-mucus, and finally bilious, and is accompanied with distressing *retching*. The *thirst* is a marked phenomena of the disease, and ice and water will be taken incessantly, although rejected only a few moments after.

The *stools* are first partly fecal, but soon watery or serous, soaking the clothing, leaving a faint greenish or yellowish stain; their odor is musty, at times fetid; their number is from ten to twenty in the day.

*Pains* precede the vomiting and purging, colicky in character.

The *fever* begins at once, the temperature varying from  $101^{\circ}$  to  $105^{\circ}$ , with morning remissions. The *pulse* is rapid and feeble, ranging from 130 to 160.

These symptoms continue but a few hours, before *rapid wasting* ensues, the body shrinks, the eyes are sunken and partly closed, the mouth partly open, the lips dry, cracked and bleeding. The child, at first *irritable* and *restless*, passes into a semi-comatose condition, the pulse becoming more and more feeble, the surface has a clammy coldness, the contracted pupils not responding to light, and the stupor deepens, death soon following, or the symptoms slowly ameliorate, convalescence being slow and tedious.

**Diagnosis.** The *entero-colitis* or inflammatory diarrhoea of childhood is constantly being mistaken for cholera infantum. The symptoms of the former are: gradual onset: with *fretfulness*, *loss of appetite*, *feverishness*, *nausea*, and moderate *vomiting*, soon followed by *diarrhoea*, the stools being semi-fluid, greenish, mixed with yellowish particles of *fæces* and undigested casein, with a sour odor, the "chopped spinach" stools, the *abdomen* distended and *tender*, moderate *fever* and *thirst*, and having a *duration* of about two weeks.

**Prognosis.** Difficult to predict the result, and so care must be

used in giving a prognosis. The duration of the choleraic symptoms is short, under five days, but relapses are common, and the sequelæ are protracted.

**Treatment.** The first indication is to arrest the vomiting and purging, for which use—

R.	Bismuth subnit., . . . . .	gr. v-x
	Mucil. acaciæ, . . . . .	ʒ ss
	Acidi carbolici, . . . . .	gr. $\frac{1}{2}$ - $\frac{1}{4}$
	Tinct. opii deodorat., . . . . .	gtt. j
	Mist. crætæ, . . . . .	ʒ iss. M.

Every two hours for a child between one and two years.

Or—

R.	Hydrargyri chlor. mit., . . . . .	gr. $\frac{1}{2}$ ij
	Bismuth subnit., . . . . .	gr. ij-v. M.

SIG.—A powder every half hour.

If these fail, or the stomach will not retain them, *tinct. opii* may be given by the rectum, with *zinci sulph.* and *amylum*.

Cases that have resisted other remedies have rapidly improved under the following :—

R.	Tinct. verat. alb., . . . . .	fʒ ij
	Morphinæ acetat., . . . . .	gr. ij
	Spts. vini gallici, . . . . .	fʒ ij. M.

Et adde ʒ j to

Aquaæ calcis,		
Aquaæ menthæ, . . . . .	āā . . . . .	fʒ j. M.

SIG.—One teaspoonful, repeated every hour, if needed.

The diet must be restricted in amount: for the first day or two gtt. v-xxx *brandy* in *barley water* at frequent intervals will be all that is required.

For *fever*, *quinina* or *aconitum* are indicated.

For *depression*, regulated nursing or feeding, every two hours, and water or ice to quench the intense thirst, and *cognac brandy*, gtt. x-xxx, every hour or two, in water.

Locally: over epigastrium, mustard or a spice poultice, or turpentine stupes.

If the *nervous symptoms* become aggravated, small dose of *potassii bromidum*, or *valerian*, which "reduces the reflex excitability, motility and sensibility," is indicated.

## ACUTE DYSENTERY.

**Synonyms.** Colitis; colonitis; ulcerative colitis; bloody flux.

**Definition.** An acute inflammation of the mucous membrane of the large intestines, either catarrhal or croupous in character; characterized by fever, tormina, tenesmus and frequent, small, inucus and bloody stools.

It occurs either in the *sporadic*, *endemic* or *epidemic* form.

**Causes.** *Sporadic* and *endemic dysentery* is caused most commonly by atmospheric changes, such as hot days with cool nights; also from malarial attacks, and rarely from errors in diet.

*Epidemic dysentery* prevails in armies, jails and tenement houses, propagated by decomposition of dysenteric stools, and the unfavorable hygienic surroundings.

*It is not contagious.*

**Pathological Anatomy.** *Sporadic dysentery* is catarrhal in character; congestion, swelling and oedema of the mucous membrane and sub-mucous tissue, with an over-production of mucus; the follicles are enlarged, from retention of their contents, the result of the swelling; the congested vessels often rupture; the mucous membrane softens in patches, and is detached, forming ulcers. Recovery follows, if the destruction of tissue is small, smooth cicatrices, minus gland structure, marking the site.

*Epidemic dysentery* is croupous in character; begins with intense congestion, swelling, and oedema of the mucous and sub-mucous tissue, with extravasations of blood and the whole mucous membrane covered with a firm, fibrinous exudation; the mucous membrane softens and sloughs, leaving large ulcers and gangrenous spots. If recovery occur, large cicatrices form, which narrow the calibre of the intestinal tube.

The mesenteric glands enlarge, soften, and abscesses form in them; the liver becomes the seat of small abscesses, from embolic obstruction of the radicles of the portal vein; the heart muscles are flabby and more or less fatty.

**Symptoms.** *Catarrhal form* begins gradually, with diarrhoea, loss of appetite, nausea, and very slight fever, which continues for two or three days, when the true dysenteric symptoms develop, to wit, pain on pressure along the transverse and descending colon, tormina or colicky pains about the umbilicus, burning pain in the rectum, with the sensation of the presence of a foreign body and a constant desire

to expel it, or *tenesmus*, which is almost constant; the stools for the first day or two contain more or less fecal matter, but they soon change to a *grayish, tough, transparent mucus*, containing more or less *blood* and *pus*; during the *tormina*, *nausea* and *vomiting* may occur; the urine is scanty and high colored; the number of stools range from five to twenty or more in the twenty-four hours.

The *duration* is about one week, the patient being much *emaciated* and *enfeebled*.

The *croupous* or *epidemic form* sets in suddenly, the stools being more frequent, containing more *blood* and *pus*, with *patches of membrane*, even *casts of the bowel*, together with more or less *gangrenous mucous membrane*; *nausea*, *vomiting*, and great *prostration*, *cold skin*, *feeble pulse* and *emaciation* with *anxious expression*, the odor surrounding the patient being *fetid*.

The *duration* of the grave symptoms is three or four days, when collapse and death occur, or slow convalescence begins, continuing for weeks.

**Complications.** *Peritonitis*; *hepatic abscesses*; *phlebitis* of the intestinal veins; *intestinal perforation*.

**Diagnosis.** *Enteritis* lacks the *tenesmus* and characteristic stools.

*Peritonitis*, when idiopathic, shows higher temperature, greater tenderness and constipation.

**Prognosis.** *Catarrhal form* favorable. *Croupous form*, the prognosis is always grave, for if recovery does occur the bowel may be crippled, from loss of structure, or from narrowing of its calibre, the result of cicatrices.

**Treatment.** Emaciation being rapid, the diet must be of the most nourishing yet bland character, to which stimulus should be added if much prostration occur.

The most common treatment is *opium*, combined with one or more *astringents*, to wit:—

R. Ext. opii,	gr. ss	
Plumbi acetat.,	gr. ij.	M.

Every two hours; or—

R. Pulv. opii,	gr. ss	
Plumbi acetat.,	gr. ij	
Pulv. ipecac.,	gr. j.	M.

Every two hours;

Or— R. Pulv. ipecac et opii, . . . . . gr. x  
 Bismuth subnit., . . . . . gr. xx. M.  
 Every two hours.

If the case is seen early the very best prescription possible is—

R. Magnesii sulph., . . . . . ʒ j  
 Acid. sulph. dil., . . . . . m v  
 Tinct. opii deodorat., . . . . . m x  
 Aquæ menth., . . . . . ʒ ij. M.

Every two or three hours, until faeces appear in the stools, when small doses of *opium* and *quinina* may be used.

*Ipecacuanha* in gr. xx-xl, is largely used in the first stages of dysentery, until the characteristic ipecac stools appear; the first doses being often rapidly rejected by the stomach, the treatment is difficult to pursue outside of hospital practice; but of its efficacy in many cases there can be no doubt.

Dr. Loomis speaks strongly of *ipecacuanha*, gr.  $\frac{1}{4}$  every half-hour, with sufficient opium to secure quietness.

Ringer recommends *hydrargyri chloridum corrosivum*, gr.  $\frac{1}{100}$ , every hour or two, which "rarely fails to free the stools from blood and slime, although in some cases a diarrhoea of a different character may continue for a short time longer."

In children the following combination is efficacious :—

R. Pulv. ipecacuanha, . . . . . gr.  $\frac{1}{4}$   
 Bismuth subnit., . . . . . gr. v  
 Cretæ prep., . . . . . gr. iiij. M.

SIG.—Every two hours.

The patient should be confined to bed in even the mildest attacks, and the stools removed at once and *disinfected*.

*Washing out the rectum* with either tepid, hot, cold or iced water, as suggested by Prof. DaCosta, adds greatly to the patient's comfort and to the decrease of the inflammatory process.

Lingering or chronic cases are benefited by one or any of the following remedies: *Terebinthina*, *acidum carbolicum*, *argentum nitras*, *cupri sulphas* or *zinci oxidum*.

### TYPHLITIS.

**Synonyms.** Inflammation of the cæcum ; catarrh of the cæcum.

**Definition.** A catarrhal inflammation of the mucous membrane of the cæcum and ascending colon ; characterized by pain, tenderness, constipation, and in certain cases a characteristic vomiting.

**Causes.** In a majority of cases *mechanical*, from the lodgment of seeds or hardened fæces.

**Pathological Anatomy.** Similar to the catarrhal inflammation of dysentery.

**Symptoms.** Pain and tenderness in the right iliac fossa and along the ascending colon, with some prominence of this region ; the bowels are usually constipated, or small liquid stools may occur from time to time, due to the accumulation of hardened fæces in the sacculated periphery of the cæcum, leaving a central canal through which the liquid contents of the upper bowel can pass.

In severe cases, "the local pain, tenderness and swelling are greater, there are impaction of fæces and no movements. There are decided fever, restlessness, and also nausea and vomiting. The vomited matters, at first the contents of the stomach, then the duodenum, with bilious matter, and ultimately, if the impaction persists, of material having the odor of fæces. With these symptoms occur great depression of the vital powers. Peritonitis is finally developed by contiguity of tissue or by rupture of the bowel."

**Duration.** The mild form lasts about one week. The severe form may terminate in subacute peritonitis, continuing about two weeks.

**Diagnosis.** The mild form is distinguished from other intestinal affections, by the localized pain, tenderness and prominence, and the constipation.

The severe form can only be distinguished from the other forms of intestinal obstruction by the history of the case and attack, and the results of treatment.

**Prognosis.** Mild form favorable. Severe form grave, although not necessarily fatal.

**Treatment.** The patient should be kept in bed, and placed on a strictly milk diet.

In mild cases, act upon the bowels, with either *oleum ricini* or *magnesii sulphas* in small doses, followed by an opium influence, to be maintained until convalescence is well pronounced.

In *severe cases*, begin an *opium* influence at once, by hypodermic injections of *morphina* guarded with *atropina*, continued until all symptoms of inflammation have subsided, when attempts to remove the accumulated fæces may be made by *irrigation of the bowel* with warm soapsuds, and the cautious administration of *magnesii sulphas* in drachm doses, every two hours.

If suppuration develop, *laparotomy* with strict *antiseptic* precautions is the indication.

*Locally.* Leeches over the cæcum followed by hot fomentations or ice bags, or cold compresses.

### PERITYPHLITIS.

**Synonyms.** Perityphlitic abscess ; suppurative appendicitis ; peri-cæcal abscess.

**Definition.** An acute inflammation of the connective tissue around the cæcum, tending to the formation of an abscess ; characterized by pain, swelling, and febrile reaction.

**Causes.** Injuries to the abdomen over the cæcum ; and also extension of the inflammation from the cæcum by perforation. Often occurs with *typhlitis*.

**Symptoms.** Begins with a *feeling of weight*, soreness and *paroxysms of acute pain* extending into the hip, thigh and abdomen, with the development of a *hard swelling* in the *right iliac region*. Its special tendency is toward *suppuration*, which is announced by *irregular chills*, *feverishness*, and *sweats*, and a feeling of *tension* and *throbbing*. Its development is slow, and if associated with *typhlitis* the symptoms of that affection are added.

**Diagnosis.** Differs from *typhlitis* by the absence of the colicky pains, dyspeptic symptoms, costive bowels and tympanites preceding the development of a tumor ; in perityphlitis the tumor is present with the development of the symptoms.

*Psoas abscess* is not associated with intestinal symptoms, and the discharge is free from a fecal odor. *Renal* and *ovarian* tumors should not be sources of error. The possibility of hernial tumors must not be overlooked.

**Treatment.** If not associated with *typhlitis*, the treatment is to allay the inflammation in the first stage, by either *ice*, *locally*, or freely *painting* with *tinctura iodi* ; if suppuration is evident, hasten by *poult-*

tices, and follow by evacuation of the pus with the *aspirator* or a free opening, conjoined with the use of *opium* and *quinina*.

If the disease is not rapidly controlled, a *laparotomy* with strict *antiseptic* precautions is indicated.

## PROCTITIS.

**Synonyms.** Catarrh of the rectum ; dysentery ; rectitis.

**Definition.** A catarrhal inflammation of the mucous membrane of the rectum and anus ; characterized by pain, tenesmus and frequent stools of hardened faeces, or of mucus, pus and blood.

**Causes.** Chief cause constipation ; also sitting on damp ground or stone steps ; habitual use of enemata or of purgatives ; diseases of the liver.

**Pathological Anatomy.** Similar to those occurring in catarrhal dysentery.

**Symptoms.** Uneasy sensations and *burning in the rectum*, with a constant desire for stool, or *tenesmus*, often so severe as to cause a *prolapse of the mucous membrane*. The stools may be either *hardened faeces* or *scybala* from the distended colon, which cause intense pain when they reach the rectum ; or the stools may be of *mucus*, *muco-pus* or *bloody* or *blood-streaked*. Generally there are present *nausea*, especially during the tenesmus, *headache*, *feverishness* and *malaise*. In severe cases there is *strangury*, and with the tenesmus, *straining with urination*.

If the case be protracted and severe, inflammation of the connective tissue around the rectum occurs, causing *periproctitis*, which usually terminates in various kinds of *fistulæ*.

**Complications.** Periproctitis ; peritonitis ; hepatic abscesses.

**Diagnosis.** In *males*, the disease cannot be confounded with any other affection, save, perhaps, hemorrhoids. In *females*, displacements of the uterus may somewhat simulate the symptoms of proctitis.

**Prognosis.** Uncomplicated cases favorable. Either of the complications adds greatly to the gravity of the affection.

**Treatment.** In cases due to constipation the chief indication is to empty the bowels, for which the *magnesia mixture* mentioned for dysentery is the most suitable remedy ; after which *emollient enemata*, with *opium*, are indicated. *Irrigation* of the bowel with warm

water once or twice daily assists in the liquefaction of the hardened faeces. Either enemata or suppositories of *glycerinum* should answer in certain cases.

Cases other than those due to constipation, *emollient enemata* and *opium*, one of the best being—

If symptoms of *periproctitis* occur, use *ice* to the parts, and if suppuration ensue, *evacuation* by a free opening and *quinina*.

## INTESTINAL OBSTRUCTION.

**Synonyms.** Intestinal occlusion; strangulated hernia; invagination; intestinal stricture; ileus.

**Definition.** A sudden or gradual closure of the intestinal canal; characterized by pain, nausea, vomiting, constipation, and finally collapse.

**Causes.** The numerous causes are arranged as follows:—

1. *Accumulations within the bowel*, of hardened faeces, or foreign bodies.
2. *Strictures*, the result of cancer, ulceration, or cicatrices.
3. *Pressure against the bowel*, from peritoneal adhesions, tumors, and abnormal growths.
4. *Strangulations*, due to the numerous forms of hernia.
5. *Invagination* or intussusception, the most common.
6. *Twisting*, volvulus or rotation of the bowel.

**Pathological Anatomy.** *Invagination* is the only form calling for special description. It is usually caused by the lower portion of the ileum slipping down into the cæcum, as the finger of a glove might be invaginated, causing thus an actual mechanical obstruction; this is produced by a spasm of the ileum, whereby its calibre is greatly diminished, thus permitting its descent into the lower bowel. Resulting from this occlusion or compression, are congestion, inflammation, with secondary constitutional reaction and death, or more rarely the invaginated bowel sloughs off, and is voided by stool, union taking place at its site and recovery following.

**Symptoms.** The onset of the symptoms may be either *sudden* or *gradual*, and are as follows:—

*Constipation*, with more or less severe *colicky pains*, not relieved by either purgatives or injections; *feeling of weight* and *soreness*, with *distention* of the abdomen and *nausea* and *vomiting*; the symptoms all grow more pronounced, the *pain* becoming *violent*, *tenderness* in limited areas, the *vomiting* becoming *stercoraceous*, the abdomen hard and tense, the *eyes sunken*, the *pulse quick* and *feeble*, the *skin cold* and covered with a clammy sweat. The above continue more or less pronounced for a week or ten days, when collapse and death occur, or more rarely there is a gradual return to health.

Cases occur rarely in which small, fecal, muco-purulent stools containing more or less blood exist, instead of constipation.

**Diagnosis.** One of the most difficult, and can only be solved by a careful study of the case along with the different causes producing the affection. The site of the occlusion can rarely be determined positively.

Intestinal obstruction may be mistaken for *intestinal colic*, *hernia*, *enteritis*, *peritonitis*, *hepatic* or *renal colic*.

**Prognosis.** Always grave, but guided by the cause. *Impacted faeces* favorable. *Invagination* less favorable, but recoveries occur; the longer the symptoms continue, the more favorable the outlook. *Strangulations* unfavorable, but many recoveries recorded. *Structures*, due to cancer, cicatrized ulcers and the like, are the most unfavorable.

**Treatment.** Stop all forms of purgatives as soon as the diagnosis of obstruction is determined.

*Opium* is indicated in all forms with pain, and is best administered in the form of *morphina*, combined with small doses of *atropina*, hypodermically.

The author has seen the most brilliant results follow the plan of *washing out the stomach* as suggested by Küssmaul, and with full doses of *atropina* hypodermically, for its action on intestinal peristalsis, and with electricity, one pole over abdomen, the other in rectum.

Cases resulting from *impacted faeces* are rapidly cured by the above plan combined with *irrigation* of the lower bowels with tepid soap-suds.

If *invagination*, raising the buttocks and lowering the chest, and repeated *injections of warmed oil*, are recommended.

Distention of the bowel by *pumping air* through long rectal tubes, or disengaging *carbonic acid gas* in the bowel, by first injecting a

solution of *so.lii bicarbonas*, and follow this with a solution of *acidum tartaricum*, about one drachm of each, pressure being made against the anus, to prevent escape; but the danger of rupture of the bowel must not be overlooked.

*Flatulent distention* can be removed by the long *aspirator* needle.

*Laparotomy* is no doubt the operation of the future, when our means of diagnostinating the location of the trouble is more exact.

The *nutrition* of the patient is best attained by injections of either peptonized foods or defibrinated blood, or both.

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## INTESTINAL PARASITES.

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### TAPEWORMS.

**Varieties.** *Tænia solium*; *Tænia saginata*; *Bothriocephalus latus*.

**Causes.** The *Tænia solium*, the "armed tapeworm," is the most common in this country. It is derived from the embryos contained in *pork*, known as the *cysticercus cellulosus*.

The *Tænia saginata*, the "unarmed tapeworm," a not uncommon variety, is derived from the embryos contained in *beef*, known as *cysticercus bovis*.

The *Bothriocephalus latus*, also an "unarmed tapeworm," the largest parasite infesting man, is supposed to be derived from an embryo found in *fish*.

The embryo or ova is introduced into the intestinal canal with the food and drink. The parasite reaches its final growth after its entrance into the intestines.

Those handling fresh meats or eating uncooked animal food are most liable to be affected.

Cleanliness is also an important factor.

**Description.** The *tænia solium* is from six to thirty feet in length, has a globular head, or scolex, a slender neck connecting its numerous flat segments or joints. The head, or scolex, measures about  $\frac{1}{16}$  of an inch, has a double circle of hooklets,—whence the term "armed tapeworm,"—and is provided with from two to four suckers. The segments or joints (*strobila*) are flat, and vary from one-eighth to one-

half an inch in length, and each contain both male and female sexual organs, the uterus being a long, numerously branched tube, in which the ova develop; the ova measure about  $\frac{1}{700}$  of an inch in diameter. An ordinary tapeworm contains some five million ova.

The parasite is firmly imbedded in the mucous membrane of the upper third of the small intestines by its hooklets and suckers.

The lower or terminal *segments* represent the adult and complete animal, and are termed the *proglottides*, which separate from the parasite and are discharged either alone or with the faeces.

The *Tenia saginata* is from ten to forty feet in length, has a rounded or oval-shaped head, measures about  $\frac{1}{10}$  of an inch and has four strong and prominent suckers, but no hooklets,—whence the term “unarmed tapeworm;” the neck is short and thick and the *segments* are larger, stronger and thicker than those of the *T. solium*.

The *Bothrioc. phallus latus* is the largest of the three Cestoda, the length ranging from fifteen to sixty feet, the head oval, measuring about  $\frac{1}{10}$  of an inch, a short neck, the segments or joints being nearly three times as broad as they are long. Its color is a dull, bluish-gray. Zoologically considered, this variety is not a true tapeworm.

**Symptoms.** Not unfrequently a *Tænia* produces no symptoms whatever.

Usually, however, there are *colicky pains* throughout the abdomen, *inordinate appetite*, *disorders of digestion*, *emaciation*, *constipation*, attacks of *cardiac palpitation*, *faintness*, *disorders of the special senses* and *pruritus* of the anus and nose. Any or all of these symptoms may be present.

A large meal will often remove the majority of the symptoms present.

In a large number of cases the discovery of the *segments* is the first intimation of the presence of the parasite.

**Treatment.** A number of remedies—termed *tæniafuges*—are used more or less successfully for the expulsion of the tapeworm, to wit: *extractum granati rad. cort. fluidum*, fʒ ss-ij, or a *decoctum granati rad. cort.* (ʒ ij bark of root, aquæ Oj), wineglassful every hour until all is taken, as suggested by Prof. Bartholow; or *oleoresina aspidii*, ʒ ss doses repeated, or *oleum pepo express.*, ʒ j-iv, followed by *oleum ricini*. *Cresota* has been successful in a number of cases. Several cures are reported from *glycerinum fʒ ij-ʒ j*, repeated p. r. n.

A much pleasanter remedy is *pelletierine*, the active constituent of

*granatum*, used in the form of the tannate, gr. x-xx, or *Tanret's solution of pelletierine*.

Cases which resist these means are often cured by the following :—

R. Chloroformi,

Ext. aspidii fld., . . . . .  $\frac{\text{æ}}{\text{æ}}$  . . . . . f  $\frac{3}{3}$  j. Emul. olei ricini, . . . . (B. Ph.) . . . .  $\frac{3}{3}$  iij. M.

SIG.—To be taken in the early morning; no food until after thorough action of the bowels.

An important precaution in the management is close attention to the "preparatory treatment" rendered essential to remove the mucus in which the *head* (*scolex*) is imbedded. It consists in the administration of a good purgative for one or two days, and a light diet, such as milk and broths, preceding the use of the *tæniafuge*.

## ROUND WORMS.

**Varieties.** *Ascaris lumbricoides*; *Oxyuris vermicularis*.

**Causes.** The *ascaris lumbricoides* is one of the most common of the parasites affecting the human family, and develops in the intestines, either after the entrance of the *ova* of the same, or from the so-called "intermediate parasites." Their entrance is effected by means of the food and drink.

The *oxyuris vermicularis* develops in the large intestines, from either its peculiar ova, or the so-called "intermediate parasite," these finding their way into the bowel with the food and drink, or by direct contact.

**Description.** The *ascaris lumbricoides*, or the *round worm*, is of a brown color, a cylindrical body, from ten to twenty inches in length and from an eighth to a fourth of an inch in circumference; the *head* terminates in three semilunar lips, each having about two hundred teeth. The *ova* are oval-shaped, are produced in immense numbers, some sixty million in a mature female, have wonderful vitality, resisting extreme heat or cold.

The *round worm* inhabits principally the *small intestines*, although it often migrates to other parts. They are found in numbers from one to several hundred.

The *oxyuris vermicularis*, *thread* or *seat worm*, resembles an ordinary piece of white thread, measuring from a sixth to a half inch in length, the *head* terminating in a mouth with three lips, the *tail* ter-

minating as a sharp point. The *ova* are oval, produced in large numbers, each female containing about ten thousand, are surrounded by a stout envelope, which increases their vitality.

The *seat worm*, as its name indicates, inhabits the *large intestines*, especially the rectum, although they frequently migrate to the sexual organs. They vary in number, sometimes the parts frequented being entirely covered.

**Symptoms.** The *ascaris lumbricoides*, or *round worm*, may be present in great numbers and yet produce no characteristic symptoms other than *gastric* and *intestinal irritation*, such as picking the nose, foul breath, colicky pains, nausea and vomiting, diarrhoea and disturbed sleep, such as tossing from side to side of bed and grinding the teeth. Any or all of these symptoms may be present or absent, the only positive proof being the passage of the parasite.

The *oxyuris vermicularis*, or *seat worm*, produces *intense itching* about the anus, with a desire for stool, the passages often containing much mucus, the result of the irritation produced by their presence. Should they migrate to the sexual organs, intense itching of these parts results, which, unless speedily corrected, leads in children to masturbation.

**Treatment.** The *ascaris lumbricoides* are readily removed by the following "worm powder" :—

R. Santonini, . . . . . gr.  $\frac{1}{4}$ -ij  
Hydrargyri chlor. mite, . . . . . gr.  $\frac{1}{3}$ -ij. M.  
Ft. chart.

SIG.—At bedtime, followed by a dose of *oleum ricini* before breakfast.

For the *oxyuris vermicularis* the above *santoninum* powder, with the use of *enemata* of *quassia*, *alumen*, *sodii chloridum*, or R., *acidi carbolicci*, gr. v-x, *aquaæ*, Oj, according to the age, the injection not to be retained. Washing the anus and external genitals with a solution of *acidum carbolicum* should also be employed.

## DISEASES OF THE PERITONEUM.

### PERITONITIS.

**Synonym.** Inflammation of the peritoneum.

**Definition.** A fibrinous inflammation of the peritoneum, either acute or chronic in character, characterized by fever, intense pain, tenderness, tympanites, vomiting and prostration. It may be limited to a part—*local*, or it may involve the whole membrane—*general*, peritonitis.

**Causes.** *Acute variety*: Intense cold; protracted irritation by blisters; blows upon the abdomen; inflammation or perforation of the stomach, intestines, gall or urinary bladder; vermiform appendix or inflammation of this part or the surrounding parts; inflammation of the pelvic viscera; septicæmia or pyæmia; erysipelas; hernia.

Many surgeons doubt that peritonitis is ever an idiopathic disease, but that rarely it does so occur is certain.

*Chronic variety*: Tuberculosis; albuminuria; scrofula; cancer; sclerosis of the liver.

**Pathological Anatomy.** *Acute form*: hyperæmia of the serous membrane, the capillaries distended and occasional extravasations of blood from their rupture; the normal secretion is arrested, and the shiny membrane becomes dull and opaque, from an exudation of pure fibrin, which is adhesive, gluing the parts together; if the inflammatory action is now arrested, it is termed *adhesive* peritonitis; if, however, the action progress, an effusion of serous fluid is poured out into the peritoneal cavity, the amount varying from a few ounces to several gallons; this is termed *exudative* peritonitis. If recovery result, the fluid is absorbed, with much of the solid exudation, the unabsorbed portions forming adhesions between the membrane and the different abdominal organs, often causing great deformity and irregularity in their relations. Pus develops if the absorption is not prompt or if any cachexia be present.

*The chronic form* follows the acute, or is associated with tuberculosis, scrofula, Bright's disease or sclerosis of the liver.

The membrane is irregularly thickened and opaque, with strong adhesions to one or more coils of the intestine, the liver or spleen; the quantity of fluid present is small, purulent or sero-purulent in character, and encysted by the agglutinated membrane.

**Symptoms.** *Acute form*; when idiopathic, the onset is sudden, with a *chill, fever, 102-3°, pulse 100-140*, wiry and tense, *severe pain*, cutting or boring in character, and *tenderness*, becoming so great that the slightest touch aggravates it, the *decubitus* being on the back, with flexed thighs; the *abdomen* is *distended* and *rigid*, from *constipation*, *effusion* and *meteorism*; the *diaphragm* is pushed up as far as the third or fourth rib in severe cases, causing compression of the lungs, and displacement of the heart, liver and spleen. There is *impaired appetite*, and *nausea* and *vomiting* are almost constant, as is *hiccup*. It is a clinical fact that a sub-normal temperature is of frequent occurrence in acute peritonitis.

*Secondary form, from extension*, begins with local and gradually increasing pain, the temperature increases, tense pulse and vomiting. If *from perforation*, it is announced by severe pain and all the symptoms of shock. If pus forms, symptoms of hectic develop.

These symptoms continue from six to eight days, when they begin to ameliorate and a tedious convalescence ensues, or pain and tenderness grow more marked, strength fails, surface cold, pulse rapid, and collapse, with hippocistic face, to wit: anxious expression, pinched features, sunken eyes and drawn upper lip.

*Chronic form*; irregular *chills, fever* and *sweats*; *distended abdomen*, *constipation*, alternating with *diarrhœa*; diffused *tenderness*, with *points of intenseness* and *hardness*; *colicky pains* during digestion, *rapid emaciation* and failure of strength. Usually, the lower portions of the abdomen give a dull note on percussion, from the presence of fluid, or scattered points of dullness, showing the presence of encysted fluid.

**Diagnosis.** The question of diagnosis in this disease is of great importance, as it so frequently, if not always, is associated with the diseases and accidents of the abdomen. *Acute gastritis* differs from peritonitis in having a history of corrosive poisoning, severe pain, limited to the stomach, with early and severe vomiting; while the latter has fever, diffused abdominal pain and tenderness, with decided distention.

*Acute enteritis* has localized pain and tenderness with marked diarrhœa; constipation being the rule in peritonitis.

*Rheumatism of the abdominal muscles* occurs with a rheumatic history, is subacute, lacks the great abdominal distention of peritonitis, and while tenderness exists, it is not aggravated by deeper pressure.

*Biliary colic*, or the passage of a gall-stone, has, as a prominent symptom, excruciating pain, localized over the common bile duct, which is of a paroxysmal character and followed by jaundice. In *renal colic* the acute pain follows the course of the ureters, with retracted testicle and altered urinary secretion.

**Prognosis.** *Idiopathic cases* favorable, and especially if they continue longer than a week, as fatal cases usually end during the first week. Cases from perforation unfavorable.

*Chronic peritonitis* being generally of tuberculous origin, the prognosis is unfavorable, although partial or complete recovery results in the cases following the acute form of the disease.

**Treatment.** *Acute form:* Idiopathic and robust cases, locally, *leeches* or *wet cups*, followed by *cold* or *hot* applications, as most agreeable to the patient, or covering the abdomen with a *blister*; adynamic cases, *dry cups*, followed by warm applications medicated with *tinctura opii*.

The profession are divided between two plans of treatment of peritonitis, one side favoring *opium* and the other party as strongly urging *saline purgatives* and *laparotomy*.

Prof. DaCosta says *opium* and *quinina* are the remedies indicated at the onset of the disease, to wit: at once hypodermic of *morphina*, gr.  $\frac{1}{4}$ - $\frac{1}{3}$ , maintaining the effect by hourly doses of either *morphina* or *opium*, by the mouth. Prof. Clark ascertained the tolerance of *opium* in this disease, by the tremendous amounts used in a case under his care; the first day he gave 200 grs., the second day 472 grs., the third day 236 grs., fourth day 120 grs., fifth day 54 grs., sixth day 22 grs., and on the seventh day 8 grains. Prof. Clark found that, as a rule, however, *morphina*, gr.  $\frac{1}{6}$ - $\frac{1}{4}$ , every two hours, would maintain the effects of the drug. The *opium* should be guarded with sufficient doses of *atropina*. *Quinina*, gr. v, every four hours until exudation, after which gr. ij, four times a day, is of marked benefit.

While the *opium* treatment places the patient as well as the bowels "in splints" and relieves the pain, it is urged by the advocates of *saline purgatives*, however, that instead of locking up the bowels, the use of salines puts the bowels into active peristaltic action, thereby the peritoneal cavity is drained of the products of inflammation and the inflamed surfaces are relieved of all engorgement by a thorough depletion of the vessels in the intestinal walls, the pulse and temper-

ature are improved, the pain is lessened as quickly as by opium, and the formation of adhesions and bands is prevented.

Should the active symptoms continue under either plan of treatment, *laparotomy* with thorough *antiseptis* is indicated.

The decline of the vital powers must be averted by *regulated nutrition and free stimulation*.

*Locally*, an ointment of *belladonna* and *hydrargyrum* are of advantage.

During *convalescence*, perfect quiet, nourishing diet, moderate stimulation, scattered flying blisters, and the following—

R.	Potassii iodidi, . . . . .	gr. v-x
	Ferri pyrophos., . . . . .	gr. ij
	Tinctura lavandulæ comp., . . . . .	m <sub>l</sub> xv
	Aquæ destillatæ, . . . . . ad . . . . .	3 ij.

M.

Every six hours,

should constitute the treatment, with tonic doses of *quinina*.

Peritonitis from *perforation*, absolute quiet, hypodermic injections of *morphina*, ice locally, and stimulants per mouth, rectum, or hypodermically, and *laparotomy*.

*Chronic peritonitis*; locally *tinctura iodi*, and internally *opium*, for pain; *potassii iodidum* as an absorbent, with nourishing diet, *oleum morrhuae* and *stimulants*, and rest in bed.

## ASCITES.

**Synonyms.** Dropsy of the abdomen; peritoneal dropsy.

**Definition.** A collection of serous fluid in the abdomen, or more correctly in the peritoneal cavity; characterized by swollen abdomen, fluctuation, dullness on percussion, displacement of viscera, embarrassed respiration, *plus* the symptoms of its cause.

**Causes.** Ascites may form part of a general dropsy, to wit: cardiac or nephritic; the most common factor in its production is *mechanical obstruction* of the portal system, from cirrhosis of the liver, tumors, diseases of the heart or lungs.

**Pathological Anatomy.** The quantity of fluid in the peritoneal sac ranges from a few ounces to many gallons. It is generally of a straw color, or at times greenish, and is transparent, having an *alkaline reaction*. When blood is present in any great quantity, it

points to cancer as a cause. The peritoneum becomes cloudy, sodden, and thickened, from long contact with the fluid.

**Symptoms.** The onset is insidious, and considerable swelling of the abdomen occurs before the disease attracts attention. *Constipation*, from pressure of the fluid on the sigmoid flexure. *Scanty urine*, from pressure on the renal vessels. *Embarrassed respiration* and *cardiac action*, from pressure on the diaphragm upward. The *umbilicus* is forced outward.

*Physical signs*; on *palpation*, a peculiar wave-like impulse is imparted to the hand laying on the side of the abdomen, while gently tapping the opposite side.

*Percussion*; patient erect, the fluid distends the lower abdominal region, with *dullness* over the site of the fluid and a *tympanitic note* above; if the patient turns on his side the fluid changes, and dullness over the fluid, tympanitic over the distended intestines.

**Diagnosis.** *Ovarian tumors* differ from ascites in the history, in that the enlargement is limited to the iliac fossa, instead of a uniform abdominal enlargement, not changing its position when the patient changes posture, and by the detection of a tumor by conjoined manipulation through vagina, or by rectal exploration.

*Pregnancy* differs from ascites in the character of the enlargement, the history, absence of menses, increase of mammae, change in the neck of the uterus, absence of fluctuation, and the presence of the sounds of the foetal heart.

*Distention of the bladder* has been mistaken for ascites; the points of distinction are, in the former the history, presence of tenderness over the bladder, rounded outline of the percussion dullness, and the relief afforded by the catheter.

*Chronic peritonitis* is differentiated by the history, pain, tenderness, more or less vomiting, thickened abdominal walls, and its generally being associated with tubercle or cancer.

*Chronic tympanites* presents the enlarged abdomen, but lacks the history, the dullness and the fluctuation, giving instead a tense abdomen and a universal tympanitic note.

**Prognosis.** Influenced by the causes producing it. *Idiopathic ascites*, which is most rare, terminates in health within a few weeks. If *peritoneal*, generally favorable. If from *organic disease*, most unfavorable, for while the dropsy may be removed, it as rapidly returns.

**Treatment.** The first indication is to treat the cause of the ascites, and the second to remove the fluid.

Three modes of removing the fluid present themselves, to wit: *first*, by hydragogue cathartics, *second*, diuretics, and *third*, tapping. The first and second modes may be combined, as follows:—

R. Pulv. jalapæ comp., . . . . . 3*j-ij*  
In water, an hour before breakfast;

And—R. Potassii acetat., . . . . . gr. x-xx-xl  
Tinct. scillæ, . . . . . 3<sup>ss</sup>  
Infus. digitalis, . . . . . f 3 iss. M.  
Every six hours.

Or instead use the following:—

R. Hydrargyri chlor. mite, . . . . . gr. iiij  
Ext. opii, . . . . . gr.  $\frac{1}{2}$  M.  
Et ft. pil.  
SIG.—One every three or four hours.

If these fail, as they certainly will after a time, the embarrassed respiration and cardiac action will call for *tapping*, which may be done with the *trocar*, or better still, the *aspirator*.

## DISEASES OF THE BILIARY PASSAGES.

### CATARRHAL JAUNDICE.

**Synonyms.** Catarrh of the bile ducts; icterus.

**Definition.** An acute catarrhal inflammation of the mucous membrane of the bile ducts and of the duodenum; characterized by gastro-intestinal derangement, yellowness, itching of the skin, feverishness and mental depression.

**Causes.** Excesses in eating and drinking; a debauch; malaria; climatic, as cool nights succeeding warm days.

**Pathological Anatomy.** The mucous membrane of one or more of the bile ducts or of the duodenum becomes hyperæmic, swollen and thickened, from an effusion of serum into the sub-

mucous tissue; the result of this condition is the closure of the biliary passages, thereby impeding the outward flow of bile. The bile in the hepatic ducts being retained by the obstruction, the result is a staining of the liver substance and an absorption of bile, and its appearance in the blood.

**Symptoms.** Begins by *epigastric distress, coated tongue, impaired appetite, nausea*, with, perhaps, *vomiting and looseness of the bowels* and *slight feverishness*, the phenomena of a gastro-intestinal catarrh. In from three to five days the *eyes become yellow*, and *jaundice* gradually appears over the whole body; the feverishness disappears, the *skin becomes harsh, dry and itchy*, the *bowels constipated*, the *stools whitish or clay-colored*, accompanied with much *flatus* and *colicky pains*; the *urine heavy and dark*, loaded with urates and containing biliary elements.

A few drops of the urine placed on a whitish surface, and a drop or two of nitric acid made to flow against it, will exhibit the following "*play of colors*;" a *greenish tint*, from the conversion of bilirubin into biliverdin, quickly followed by *blue, violet, red, and yellow, or brown*.

When the *jaundice* is complete, the *surface is cold*, the *heart's action slow*, the *mind torpid and greatly depressed*, and pain or tenderness on pressure over the hepatic region.

**Duration.** In from three to five days after the jaundice appears, the symptoms subside, save the torpid bowels, depression and discolored skin, which slowly disappear, often requiring a week or two.

**Diagnosis.** After the appearance of the jaundice, mistakes are impossible.

The numerous diseases of which jaundice is a symptom will be differentiated when treating of them.

**Prognosis.** Always favorable; if the attacks are of frequent occurrence, however, they are apt to lead to organic hepatic changes.

**Treatment.** At the onset, *quinina*, gr. x, morning and night, may modify the disease, but as soon as the diagnosis is established the indications are for *diaphoretics, diuretics and purgatives*.

For *diaphoresis*, the *warm bath*, to which *potassii carbonas*, 3j, may be added, morning and night.

For *diuresis*, *potassii bitartras lemonade*, every four hours.

For *purgation*, either *sodii pyrophos.*, 3j-ij, every four hours, well diluted, *ammonii murias*, gr. xv-xx, every five hours, well diluted

*magnesii sulphas*, gr. xx, every couple of hours, or *hydrargyri chloridi mite*, gr.  $\frac{1}{4}$ , every hour until free purgation.

A special plan, which is said to be effective, is with "enemata of cold water. By means of an irrigating apparatus the large intestine is well distended with water once a day for several days. The first enema has a temperature of 60° F., and subsequent injections are a little warmer. The increased peristalsis of the bowels and the reflex contractions of the gall bladder dislodge the mucous lining obstructing the gall ducts. When the bile flows into the intestine, digestion is resumed and the catarrhal inflammation subsides." Other remedies may be conjoined with the irrigation method.

Restricted diet, avoiding all starchy, fatty or saccharine articles, milk being the most suitable article of diet.

For convalescence—

R. Acid. nitro-hydrochlorici dil., . . . . . gr. v-x  
Elix. taraxaci comp., . . . . . 3j-ij.

M.

Before meals.

## BILIARY CALCULI.

**Synonyms.** Hepatic calculi; gall stones; hepatic colic.

**Definition.** Concretions originating in the gall bladder, or biliary ducts, derived partly or entirely from the constituents of the bile. Their presence is generally unrecognized until one or more attempt to pass along the ducts, when an attack of *hepatic colic* is produced.

**Causes.** Gall stones result from the *precipitation* of the crystallizable *cholesterine*, and its combination with inspissated mucus in the gall bladder or ducts.

A disease of middle life, and more frequent in the obese, and in women.

Gall stones are said to be common in carcinoma of the stomach or liver.

**Pathological Anatomy.** Cholesterine is the chief constituent of biliary calculi. Commonly several stones exist, and rarely one; as many as six hundred are recorded. They are generally found in the gall bladder or cystic duct, rarely in the liver or hepatic duct.

**Symptoms.** *Hepatic colic* begins suddenly, at the moment a gall stone passes from the gall bladder into the cyst duct.

The patient is seized with a *piercing, agonizing pain* in the region of the gall bladder, and spreading over the abdomen, right chest and

shoulder; the *abdominal muscles* are cramped and tender; there is *nausea* and *vomiting*; a small, feeble *pulse*, *cool skin*, *pale*, *distorted*, *anxious face*, with, may be, fainting, spasmodic trembling, chills, or convulsions.

The paroxysm continues from an hour or two to several days, with remissions, but entire relief is not afforded until the stone reaches the duodenum, when the pain suddenly ceases.

*Jaundice* usually follows the paroxysm of pain. When the calculi reaches the intestines, the pain, nausea and vomiting cease, the appetite returns, and the jaundice soon disappears.

Should the calculi become impacted, *ulcerative perforation* and consequent *peritonitis* follow, the calculi discharging by the intestine, stomach, or through the abdominal walls.

**Diagnosis.** The malady should not be mistaken if *severe pain*, diverging from the hepatic region, and *nausea* and *vomiting* are present, suddenly terminating, and followed by slight *jaundice*.

**Prognosis.** Usual termination is in health. The prognosis becoming more unfavorable if *ulcerative perforation* result.

**Treatment.** For the *colic*, hypodermic injections of *morphina*, gr.  $\frac{1}{6}$ - $\frac{1}{3}$ - $\frac{1}{2}$ , combined with *atropina*, gr.  $\frac{1}{20}$ , and warm fomentations over the hepatic region, are indicated.

Prof. Bartholow strongly urges the following prophylactic treatment: Carefully regulated diet, abstinence from all fatty and saccharine substances, daily exercise, stoppage of all excesses, and the long use of *sodii phosphas*, 3j, before meals, well diluted, to which may be added, if gastro-intestinal catarrh be present, *sodii arsenias*, gr.  $\frac{1}{20}$ , or *aurii et sodii chloridum*, gr.  $\frac{1}{20}$ , together with either Vichy or Saratoga Vichy water.

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## DISEASES OF THE LIVER.

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### CONGESTION OF THE LIVER.

**Synonyms.** Torpid liver; biliaryness.

**Definition.** An abnormal fullness of the vessels of the liver, with consequent enlargement of that organ; it is termed *active* when arterial; *passive* when venous. The condition is charac-

terized by torpidity of the digestive and mental functions, and slight jaundice.

**Causes.** *Active congestion*; heat, atmospherical or artificial; habitual constipation; malaria; excess in eating and drinking; alcoholic or malt liquor. In females, an arrested menstrual epoch may give rise to an attack.

*Passive congestion*; cardiac and pulmonary diseases.

**Pathological Anatomy.** The liver is enlarged in all directions, and is abnormally full of blood. Cases due to obstructive diseases of the heart or lungs present the so-called "nutmeg liver," to wit: "At the centre of each lobule the dilated radicle of the hepatic vein, enlarged and congested, may be discerned, while the neighboring parts of the lobule are pale," the radicles of the portal vein containing less blood.

Long-continued congestion establishes atrophic degeneration of the organ; the decrease in size is confounded with the condition of cirrhosis, but the "atrophic liver" is smooth, while the "cirrhotic liver" is nodulated.

**Symptoms.** *Active congestion*; following cause, rapidly produced malaise, aching of limbs, evening feverishness, headache, depression of spirits, yellowish tongue, disgust for food, nausea, and, may be, vomiting, constipation, scanty, high-colored urine, with a feeling of fullness, weight, and soreness in the hepatic region, with dull pain extending to the right shoulder, and slight jaundice, the eye yellow, and the complexion muddy. Duration about a week.

*Passive congestion*; onset gradual, with a feeling of weight and fullness in the hepatic region, slight jaundice, and symptoms of gastro-intestinal catarrh.

*On percussion* the hepatic dullness is increased in all directions.

**Diagnosis.** Acute congestion is continually confounded with catarrhal jaundice; the latter begins with marked gastro-intestinal symptoms and distinct jaundice; in the former these are less marked.

*Obstructive congestion* is diagnosticated by the clinical history.

*Atrophic or nutmeg liver* will be differentiated from cirrhotic liver when speaking of the latter.

**Prognosis.** *Active congestion* favorable, unless repeated attacks occur, rapidly succeeding each other, when "atrophic degeneration" results.

*Passive congestion* controlled entirely by the cause.

**Treatment.** Attacks due to *excess in eating and drinking*—

R. Sodii bicarb., . . . . .	gr. v
Pulv. ipecac, . . . . .	gr. ss
Hydrargyri chlor. mit., . . . . .	gr. iiij-v

repeated, or *sodii phosphatis* 3*j* every four hours until free catharsis, or small doses of *hydrargyri chloridi mite*, with *sodii bicarbonas* repeated several times, followed with *saline*, followed by

R. Acidi nitro-hydrochlorici dil., . . . . .	m <sub>v</sub> iiss
Elix. taraxaci comp., . . . . .	3 <i>ij</i> .

Before meals, and a milk diet.

Attacks due to *malaria*; the above purgative followed by *quininæ sulph.*, gr. iv, every four hours.

Attacks occurring with cardiac or pulmonary diseases must be managed by treating the cause.

The tendency to constipation must be overcome by the *saline laxative waters*, to wit: Congress or Hathorn, Pullna or Friedrichshall, or *sodii phosphas*, 3*j*-ij, three or four times daily, well diluted.

*Locally*, in acute attacks, hot cloths or sinapisms, are of benefit.

In *chronic cases* benefit follows, *elix. quininæ ferri et strychninæ* 3*j*, three times a day, and great comfort and support is given by the use of the "hydropathic belt," which is made of stout muslin, shaped to the abdomen, with cross pieces of tape on the inner side, which keeps next to the skin a fold of cloth wrung out of cold water, and a piece of waterproof cloth or oiled silk, to prevent evaporation.

In persons who seem to have a predisposition to attacks of congestion of the liver upon the slightest exposure to any of the various exciting causes, the habits and diet must be regulated, to which must be added a course of alkaline waters and regulated exercise.

## ABSCESS OF THE LIVER.

**Synonyms.** Parenchymatous hepatitis; acute hepatitis; suppurative hepatitis.

**Definition.** A diffused or circumscribed inflammation of the hepatic cells, resulting in suppuration, the abscesses being sometimes single, at times double; characterized by irregular febrile attacks, hepatic tenderness and symptoms of deranged gastro-intestinal and hepatic functions.

**Causes.** The result of the absorption of putrid material by the portal radicles in dysentery; ulcers of the stomach; malaria; blows and injuries; heat; pyæmia.

**Pathological Anatomy.** Hyperæmia, swelling, effusion of lymph, degeneration and softening of the hepatic cells; suppuration, beginning in points in the lobules and coalescing. The abscess walls consist of the liver structure, more or less changed.

The abscess may advance toward the surface of the liver, bursting into the peritoneum, intestines, stomach, gall bladder, hepatic duct or vein, or into the pleura or lungs, or externally through the abdominal walls; after the discharge of pus, cicatrization occurs, or the pus may be absorbed, the tissues around forming a dense cicatrix.

**Symptoms.** Very obscure. *Fever* simulating markedly intermittent or remittent fevers; disorders of the gastro-intestinal canal, with *obstinate vomiting, debility*, and great *irritability of the nervous system, melancholia, slight jaundice, constipation*, the *stools light colored*, and if of long duration, *typhoid symptoms*.

*Locally*, if the abscess is near the surface, *prominence of the hepatic region, throbbing, limited tenderness*, and if it tends to the surface, redness, *œdema* and fluctuation. The abscess may burst into the intestines, stomach, lungs, or pleura, the symptoms of which will be pronounced.

**Diagnosis.** Hepatic abscess may be confounded with hydatids of the liver, hepatic or gastric cancer, abscess of the abdominal walls, and purulent effusion in the right pleural cavity.

The differentiation is most difficult, but *great aid* is obtained from the use of the *aspirator*.

**Prognosis.** Unfavorable. Recoveries, however, do occur. If the abscess bursts into the lungs, bowels, or externally through the abdominal wall, the case is more favorable.

**Treatment.** *Symptomatic*, and when *pus* is present, the use of the *aspirator* to remove it, and sustaining treatment, to wit: *quinina, ferrum, alcohol, and oleum morrhuae*.

## ACUTE YELLOW ATROPHY.

**Synonyms.** General parenchymatous hepatitis ; malignant jaundice ; hemorrhagic icterus.

**Definition.** An acute diffused or general inflammation of the hepatic cells, resulting in their complete disintegration ; characterized by diminution in the size of the liver, deep jaundice, and profound disturbance of the nervous system ; terminating in death, usually, within one week.

**Causes.** Unsettled. It occurs frequently in young pregnant women, from the third to the sixth month of pregnancy. Other causes are venereal excesses ; syphilis ; action of phosphorus, arsenic or antimony.

**Pathological Anatomy.** Begins with hyperæmia of the hepatic cells, with a grayish exudation between the lobules, followed by softening, dull yellow color, and disappearance of the cells, fat globules taking their place. The liver is reduced in size and in weight. The peritoneum covering the liver is thrown into folds. The spleen is enlarged. The kidneys undergo degeneration. The blood contains a large amount of urea and considerable leucin. The urine is loaded with bile pigment, and contains albumin.

**Symptoms.** *Prodromic period* ; begins as a *gastro-intestinal catarrh*, coated tongue, nausea, vomiting, tenderness over the epigastrium, headache, quickened pulse, slight fever and slight jaundice.

*Icteric period* ; jaundice deepens, pulse slow, headache increases, and great and obstinate sleeplessness.

*Toxæmic period* ; fever, rapid pulse, more complete jaundice, pain, nausea, vomiting of blackish, grumous blood, or "coffee grounds," tarry stools, ecchymotic patches, convulsions or epileptiform attacks, coma, insensibility, death.

Percussion shows markedly decreased hepatic dullness.

**Duration.** Short. After appearance of jaundice, about six days.

**Prognosis.** Unfavorable.

**Treatment.** Entirely symptomatic. Prof. Bartholow "advises the trial of very small doses of phosphorus, as early as possible, as this remedy affects the organ specifically, and an action of antagonism may be discovered between them."

## SCLEROSIS OF THE LIVER.

**Synonyms.** Interstitial hepatitis ; cirrhosis of the liver ; hob-nailed liver ; gin-drinkers' liver.

**Definition.** An inflammation of the intervening connective tissue of the liver, chronic in its progress, resulting in an induration or hardening of the organ and an atrophy of the secreting cells ; characterized by gastro-intestinal catarrh, emaciation, slight jaundice and ascites.

**Causes.** The prolonged use of alcoholic stimulants, gin, whisky, beer, or porter ; syphilis.

**Pathological Anatomy.** *First stage* ; hyperæmia of the connective tissue (Glisson's capsule) of the liver, and the development of brownish-red connective-tissue elements, whereby the organ is increased in size and density ; this increase of the connective tissue presses upon the hepatic cells, causing them to undergo fatty degeneration.

*Second stage* ; the newly formed, imperfectly developed connective tissue contracts, causing decrease in the size and induration of the organ, its surface being nodulated. The hepatic and portal circulation is obstructed, from obliteration of their radicles.

The hepatic peritoneum is thickened and opaque, and adhesions are formed to the diaphragm, gall-bladder, and stomach.

Cases occur in which the sclerosis takes place while the organ continues enlarged ; these cases are known as *hypertrophic sclerosis*.

**Symptoms.** No characteristic symptoms of the early stage of the affection. Persistent *gastro-intestinal catarrh*, with attacks of *jaundice*, in a drinking man, are suspicious. Symptoms of the second stage are, *abdominal dropsy*, *enlargement* of the superficial *abdominal veins*, *dyspepsia*, localized *peritoneal pain*, *hemorrhages* from the *stomach* or *intestines*, muddy or slightly jaundiced skin and decided *emaciation* ; the enormously distended abdomen with thin legs are characteristic of sclerosis of the liver.

**Diagnosis.** *Atrophy of the liver*, or the nutmeg liver, is almost always confounded with sclerosis ; the former occurs most commonly with obstructive diseases of the heart and lungs, and the surface of the organ is not nodulated, nor is there a history of alcoholism.

*Cancer and tubercle of the peritoneum* have many symptoms akin to sclerosis. The points of differentiation are, great tenderness over abdomen, rapidly developed ascites, rapid decline in strength and

flesh, absence of jaundice, absence of long-continued dyspepsia, absence of hepatic changes on percussion, and the presence of tubercle or cancer deposits in other organs.

**Prognosis.** Terminates in death. Average duration after appearance of the dropsy, one year.

**Treatment.** For the changes in the hepatic structure, little, if anything, can be done; the following are some of the remedies recommended, to wit, *hydrargyri chloridum corrosivum*, gr.  $\frac{1}{60}-\frac{1}{40}$ , three times a day; *hydrargyri chloridum mite*, gr.  $\frac{1}{60}$ , three times a day; *aurii et sodii chloridum*, gr.  $\frac{1}{20}$ , after meals; *sodii phosphas*, 3 ss-j, after meals; *potassii iodidum*, after meals.

The diet must be regulated, milk being the most suitable, and avoiding fatty and saccharine foods.

The abdominal dropsy may be temporarily benefited by *purgatives* and *diuretics*, but sooner or later *tapping* becomes imperative.

### AMYLOID LIVER.

**Synonyms.** Waxy liver; lardaceous liver; scrofulous liver; albuminous liver.

**Definition.** A peculiar infiltration into, or a degeneration of, the structure of the liver, from the deposit of an albuminoid material, which has been termed *amyloid*, from a superficial resemblance to starch granules.

**Causes.** The chief cause is prolonged suppuration, especially of the bones; coxalgia; syphilis; cancer.

**Pathological Anatomy.** The liver is uniformly enlarged. It presents a pale, glistening, translucent appearance, and has a doughy consistency. On section, the surface is homogeneous, is anaemic and whitish. The deposit begins in the arterioles and capillaries, finally closing them.

The reaction with iodine and sulphuric acid affords a certain test of the amyloid or albuminoid deposits. After further cleansing, brush over the parts a solution of iodine with iodide of potassium in water, when they will assume a mahogany color, and if diluted sulphuric acid be added, a violet or bluish tint is produced.

A pretty reaction is to take a one per cent. solution of anilin violet, which strikes a red or pink color with the amyloid or albuminoid material, while the unaltered tissues are stained blue, thus showing a beautiful contrast.

The amyloid change involves the spleen, kidney, intestines, and their organs.

**Symptoms.** Nothing characteristic. Hepatic dullness increased, with prominence over the liver. Absence of pain. Splenic dullness increased. Emaciation and anaemia. Urine increased in amount, pale, and containing some albumin, due to amyloid changes in the kidneys. Disorders of digestion, with diarrhoea, due to amyloid changes in the intestines. Jaundice is rare. Ascites seldom occurs.

**Prognosis.** Unfavorable. The progress is rapid or slow, depending upon the cause.

**Treatment.** No specific. Prof. DaCosta recommends *ammonii murias* gr. x-xx three times daily, for several weeks, then change for same length of time to *syrupus ferri iodidum*, beginning with  $\text{m}_x$  gradually increased to  $f_3 j$  after meals, then to the former again, and so on, for months. Symptomatic, with prolonged use of *ferrum*, *syr. calcii lacto-phosphas* and *oleum morrhuae*.

## HEPATIC CANCER.

**Synonym.** Carcinoma of the liver.

**Definition.** A peculiar morbid growth, progressively destroying the hepatic tissue; characterized by disorders of digestion, anaemia, emaciation, jaundice and ascites, and terminating in the death of the patient.

**Causes.** Hereditary, when it is termed *primary* cancer; from extension from other organs, when it is termed *secondary* cancer. It is a disease of advanced life, from forty to sixty years.

**Pathological Anatomy.** The most common variety of cancer of the liver is a compound of the medullary and scirrhus.

The cancer cells develop from the interlobular connective tissue, and as they grow the hepatic cells atrophy, the result of the pressure of the new growth. The branches of the hepatic artery enlarge and permeate the growth, while the branches of the portal vein are compressed and atrophied, thereby blocking up the portal circulation.

The cancer may develop in nodules or masses, or may be diffused; the nodules vary in size, and those on the surface are rounded, with a central umbilication. The peritoneum is adherent, cloudy and thickened.

**Symptoms.** The development of hepatic cancer is preceded by

a history of dyspepsia, flatulency and constipation. The *uneasiness, weight and pain*, increased by pressure, are noticed; *jaundice, ascites, occasional intestinal hemorrhages, emaciation, feebleness, anæmia, cold, dry, harsh skin, pinched features, with dejected, worn expression*. Fever never occurs. The hepatic dullness is increased, with pains on palpation, and the liver is indurated, irregular and nodulated.

The duration is less than a year from the time the disease is recognized.

**Diagnosis.** The points of differentiation are the *age, cachexia, pain and tenderness, enlarged liver with hard nodules, and rapid progress*.

**Prognosis.** Always terminates in death.

**Treatment.** Early, symptomatic. Sooner or later *opium* must be used, to relieve the terrible and persistent pain.

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## DISEASES OF THE KIDNEYS.

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### THE URINE.

The *normal quantity* of urine varies from twenty to fifty ounces in the twenty-four hours; it is *decreased* by free perspiration and *increased* by chilling of the skin.

The *normal color* is light amber, due to *urobilin*; the color deepens if the quantity voided be decreased, and *vice versa*.

The *normal reaction* is slightly *acid*, due to the *acid sodic phosphate, uric and hippuric acids*. After meals it may be *neutral* or even *alkaline*.

The *normal specific gravity* varies from 1.008 to 1.020; it is *low* when an increased quantity is passed and *high* when the quantity is diminished.

The most important organic and inorganic solid constituents held in solution are, *urea* (the index of nitrogenous excretion), from 308 to 617 grains daily; *uric acid*, from 6 to 12 grains; *urates of sodium, ammonium, potassium, calcium and magnesium*, from 9 to 14 grains; *phosphates of sodium, etc.,* from 12 to 45 grains, and *chlorides of sodium, etc.,* from 154 to 247 grains daily.

I. Quantitative test for *urea*, by hypobromite of sodium (Davy's Method).

Fill a graduated glass tube one-third full of *mercury*, and add one-half drachm of the 24 hours' urine; then fill the tube evenly full with a saturated solution of *hypobromite of sodium*, and close it *immediately* with the thumb; invert the tube and place its open end beneath a sat. sol. of *chloride of sodium*; the mercury flows out and is replaced by the solution of salt; *nitrogen gas* is disengaged from the urea in the upper part of the tube.

Each *cubic inch* of gas represents .645 gr. of urea in the half drachm, from which the amount passed in 24 hours may be calculated.

Urine containing an excess of urates and uric acid, on *cooling*, precipitates them (viz.: "brickdust deposits" in "pot de chambre"). *Heat* dissolves them to a certain extent.

*Nitric acid* deprives the soluble *neutral urates* of their bases, and produces, at first, a faint, milky precipitate of *amorphous acid urates*; adding more acid, the still less soluble *red crystals of uric acid* are deposited.

Put a small quantity of *nitric acid* in a test tube, and pour the urine carefully down the sides of the tube upon it, and a *zone of yellowish-red uric acid* and altered coloring matter will form at their union; and a dense, milky *zone of acid urates* above this, which, however, dissolves upon agitation. (See *albumen test*.)

To *three ounces* of the 24 hours' urine (after being slightly acidulated, boiled and filtered while hot) add *one-tenth* as much *nitric acid*; place in a cool place for 24 hours, then collect the deposit of *uric acid* on a weighed filter, wash it thoroughly, and dry at  $212^{\circ}$  F. The increased weight represents the *uric acid* in part excreted, approximately.

II. Tests for *urates* and *uric acid* by nitric acid.

III. Quantitative test for *uric acid* by nitric acid.

IV. Test for the earthy and alkaline phosphates by the magnesian fluid.

*Heat or liquor potassa* increases the cloudiness caused by earthy calcium and magnesium phosphates. *Acetic or nitric acid* clears it, by dissolving them.

V. Test for the chlorides by nitrate of silver.

To a convenient quantity of urine add a small amount of nitric acid, to prevent the formation of the phosphates and other salts of silver; filter this, if cloudy; add to this one drop of a solution of nitrate of silver (1 part to 8) and the precipitate of white cheesy lumps of *chloride of silver* denotes that the amount of *chlorides* are normal; if, however, only a faint milkiness occurs, the *chlorides* are diminished.

VI. Test for mucus by acetic acid and liquor iodi comp.

*Mucus* alone is not visible, but causes cloudiness, from having entangled mucus or pus corpuscles, epithelium, granules of sodium urate, crystals of oxalate of lime and uric acid in various amounts.

Add to the urine a little *acetic acid*, or, in addition, a few drops of *liquor iodi comp.*, when threads and bands of *mucin* are made visible. The addition of *nitric acid* dissolves them.

Slightly acidulate the urine, if necessary, by addition of nitric or acetic acid, and *boil*; this causes a *white* deposit of *coagulated albumin*, which is not dissolved by nitric acid, unless the acid is in excess.

*Nitric acid* causes a *white* deposit of *coagulated albumin*, which is dissolved if a

VII. Test for albu-

*min by heat and nitric acid.*

{ large excess of acid be added. A delicate test is to put the *nitric acid* in the tube first, and then gradually pour the urine down the side of the tube upon it, when a *white zone*, or *ring of coagulated albumin* appears. *Precaution*, see tests Nos. 3, 4, 9 and 11.

VIII. Quantitative test for *albumin*. Approximately.]

Add a few drops of *nitric acid* to a proportion of the urine, and *boil*; set this away for 24 hours, and the proportionate depth of the resulting deposit is the comparative indication, viz.,  $\frac{1}{4}$ - $\frac{1}{2}$ , etc.

IX. Test for *blood* by heat and nitric acid.

*Heat or nitric acid* causes deposit of albumin, with the coloring matter changed to a *dirty brown*.

X. Test for *blood* by heat and caustic potash (Heller's).

*Heat the urine, then add caustic potash and heat anew.* The phosphates are thus precipitated, taking with them the coloring matter of the blood, which imparts a *dirty, yellowish-red* color to the sediment, viewed by reflected light, and when seen by transmitted light, gives a splendid *blood red color*.

Neither the coloring matter of the blood, nor that of the bile, is precipitated with the phosphates, so that coloration of urine which shows this reaction cannot be ascribed to the presence of the latter pigments.

When the quantity of blood in the urine is very large, it is of a *dark or brownish-red*, and after standing, forms a coagulum of blood at the bottom of the vessel.

*Caution.* Heat or nitric acid causes coagulation of the albumin in pus.

XI. Test for *pus* by liquor potassa.

Add to the urine, or preferably to its deposit from standing, an equal volume of *liquor potassa*; when well mixed, a *viscid gelatinous fluid* or mass is formed, which pours like the white of an egg, or jelly.

XII. Test for *bile* by "fuming" or red nitric acid.

Allow a specimen of urine and a few drops of red "fuming" *nitric acid* to gradually intermingle on a porcelain dish, and a "play of colors," *green, blue, violet, red and yellow or brown*, occur, if biliary coloring matter be present.

XIII. Test for *bile pigment* by pure hydrochloric and pure nitric acids (Heller's).

Pour into a test tube about  $1.6 \text{ f} \frac{1}{3}$  of pure *hydrochloric acid*, and add to it, drop by drop, just sufficient *urine* to distinctly color it. The two are mixed. Then drop down the side of the test tube pure *nitric acid*, which will "underlay" the mixture of hydrochloric acid and urine. At the point of contact between the mixture and the colorless nitric acid a handsome "play of colors appears." If the "underlying" nitric acid is now stirred with a glass rod, the set of colors which were superimposed upon one another will appear alongside of each other in the entire mixture, and should be studied by transmitted light.

If the hydrochloric acid, on addition of the biliary urine, is colored *reddish-yellow*, the coloring matter is *bilirubin*; if it is colored *green*, it is *biliverdin*.

XIV. Test for *sugar* by liquor potassa and heat (Moore's).

Add to the urine half its volume of *liquor potassa*. (Caution. This may give a white, flaky precipitate of the earthy phosphates, which should be removed by filtering.) Now boil; this causes, at first, a *yellow-brownish* color, becoming *darker* if much sugar is present, due to glucic, and finally to melasic acid.

XV. Test for *sugar* by subnitrate of bismuth, liquor potassa and heat.

Add to the urine half its volume of *liquor potassa*, and then a little *bismuth subnitrate*, shake and thoroughly boil; the presence of sugar reduces the salt and *black metallic bismuth* is deposited, or if but little sugar, a *gray deposit* occurs.

*Caution.* Albumin must be absent.

XVI. Test for *sugar* by a solution of cupric sulphate, liquor potassa and heat (Trommer's).

Add to the urine a few drops of a solution of *cupric sulphate*, and then its own volume of *liquor potassa*. (*Caution*. On first addition a light greenish precipitate occurs, which, on further addition of the reagent, if sugar or certain other organic matters are dissolved, giving a transparent blue liquid.) Now boil, and a yellowish precipitate of *hydrated cupric suboxide*, occurring at once, denotes the presence of sugar.

*Caution*. Albumin must be absent.

Take of Pavy's solution of *cupric protoxide*, recently prepared (see margin), 200 minims or a multiple of this quantity, and boil in a porcelain dish; while boiling, add, minim by minim, from a measured portion of the 24 hours' urine, and it gives a yellowish precipitate of *hydrated cupric suboxide*, if sugar be present.

Note carefully the gradual disappearance of the blue color, and when completed (best determined by looking through the margin of the fluid against the white porcelain dish), from the amount of urine used, determine the amount of sugar passed daily. The quantity of urine containing one grain of sugar being just sufficient to reduce the 200 minims of the copper solution.

Take two measured specimens from the 24 hours' urine, and to one add a little yeast. Place each specimen in a temperature of 75° to 80° Fah.; in 24 hours, fermentation having destroyed the sugar in the one containing the yeast, the difference in the specific gravity of the two specimens expresses the number of grains in each ounce of the urine. Approximately.

XVII. Quantitative test for *sugar* by Pavy's solution, to wit:—

R.  
Cupric sulphate, gr. 320  
Neutral potassic tartrate, . . . gr. 640  
Caustic potash, gr. 1280  
Distilled water, f $\frac{3}{3}$  20

Keep corked.

XVIII. Quantitative test for *sugar* by fermentation and the specific gravity.

## CONGESTION OF THE KIDNEYS.

**Synonyms.** Renal hyperæmia; catarrhal nephritis.

**Definition.** An increase in the amount of blood in the vessels of the kidneys; when arterial, it is termed *active congestion*; when venous, *passive congestion*; characterized by pain, frequent desire for urination, the amount of urine scanty, high-colored, occasionally containing albumin or blood.

**Causes.** *Active*; from cold; irritating substances eliminated by the kidneys, to wit: turpentine, copaiba, cantharides; during the eruptive or continued fevers; injuries over the kidneys.

*Passive*; obstructive diseases of the heart or lungs, and pressure of the pregnant uterus.

**Pathological Anatomy.** The kidneys enlarge and increase in weight; increased redness (the color being bluish if *passive*), with points of vascularity, corresponding to the Malpighian bodies, and occasionally minute ecchymoses. The abnormal hyperæmia causes a catarrhal state of the ducts of the pyramids, with shedding of their epithelium.

If mechanical (*passive*) obstruction continues for some time, increase of the connective tissue, with consequent induration and contraction results, or a form of chronic Bright's disease.

**Symptoms.** *Active variety*; pain over kidneys and following the course of the ureters into the testicles and penis, *irritable bladder*, almost constant and pressing desire for urination, the *urine scanty, high-colored*, and occasionally bloody, with fibrin, casts and albumin; there is, as a rule, no pain during the act of urination. The constitutional symptoms are headache, slight nausea, vomiting and a general feeling of discomfort.

If the condition persist, *inflammation* of the kidney results.

*Passive*; the kidney changes are marked by the *lung or heart trouble*, until *dropsy, scanty, high-colored, albuminous urine* is observed.

**Prognosis.** *Active*; if recognized and properly treated, favorable.

*Passive*, controlled by the cause, and if prolonged, terminating in *interstitial nephritis*.

**Treatment.** Rest of the body; dry or wet cups over the loins; dilute the urine by increasing the quantity of bland fluids consumed; *saline purgatives*; warm bath or other mild diaphoretics; *infusum digitalis* is pre-eminently the remedy for congestion of the kidneys; if great *irritability of the bladder*, *camphora*, gr. ij-iv, every four hours,

combined with *morphinæ sulph.*, gr.  $\frac{1}{12}$ — $\frac{1}{6}$ , or the hypodermic injection of *morphina*, gr.  $\frac{1}{12}$ .

The treatment of the passive form resolves itself into the treatment of the cause.

### ACUTE BRIGHT'S DISEASE.

**Synonyms.** Acute desquamative nephritis; acute parenchymatous nephritis; acute tubal nephritis.

**Definition.** An acute inflammation of the epithelium of the uriniferous tubules; characterized by fever, scanty, high-colored or smoky urine, dropsy, with more or less constant nervous phenomena, the result of acute uræmia.

**Causes.** The young more liable than the aged; cold and exposure; scarlatina; persistent use of irritants, to wit: turpentine and cantharides. Blows and injuries of the back have caused this affection.

**Pathological Anatomy.** The kidneys are generally swollen, engorged, more vascular, and of a red color; in the second stage the organ remains large, irregularly red, especially the cortex; the tubules are engorged and filled with epithelium, blood corpuscles and fibrin. The capsule is easily detached, and is more opaque than normal.

If a favorable termination, the swelling lessens, the vascularity diminishes, the tubules returning to a normal condition.

**Symptoms.** Usually begins suddenly. *Fever*, with *nausea* and *violent and persistent vomiting*, dull *pain* over the kidneys, following the ureters; frequent desire to urinate; diarrhoea; *skin* harsh and dry; *pulse* quick, tense and full. Soon *dropsy* appears, the eyelids and face become puffy and swollen, followed by general oedema of the extremities, scrotum and abdominal walls. If the attack follow scarlatina there are from the onset much greater pallor and general debility.

The *urine* is of high specific gravity, scanty, smoky (like beef washings) in color, due to the presence of *blood*. *Albumin* is present in large quantities, and the microscope reveals *casts* of the uriniferous tubules, blood corpuscles, uric acid, urates and oxalate crystals and epithelium.

*Duration* from one to four weeks.

**Complications.** *Pericarditis*, *pleuritis*, *pneumonitis*, *peritonitis*,

or acute *uræmia*, from retention and decomposition of urea in the blood.

**Diagnosis.** The history, fever, scanty, smoky, albuminous urine, with dropsy beginning in the face, should prevent any error.

*Albuminuria* may be confounded, on account of the presence of albumin in the urine, but lacks the clinical history, usually occurring in the course of some constitutional affection, to wit: diphtheria, cholera, yellow fever or erysipelas.

**Prognosis.** Favorable. Majority of cases recover under prompt treatment. Rarely passes into chronic Bright's disease. *Uræmic* symptoms add to the gravity of the prognosis.

**Treatment.** Absolute rest in bed. Milk diet, or if much depression, also weak animal broths and oysters. Drink freely of water, but neither tea, coffee nor stimulants. Counter-irritation over the kidneys by dry or wet cups, and poultices of *digitalis*.

For the dropsy, purgation by *pulv. jalapæ comp.*, 3j, in water, before breakfast, or *elaterium*, gr.  $\frac{1}{5}$ .

*Diaphoresis* by warm baths, or *extractum pilocarpi fluidum*, m x-xxx, every three or four hours, or *vinum ipecacuanhæ*, gtt. j-ij, every half hour.

*Diuresis*, by—

Rx.	Potass. acetas,	gr. x-xx
	Infus. digital.,	fʒ ij
	Infus. juniperi,	fʒ ij.
M.		

Every two or four hours.

As soon as the blood disappears from the urine, a course of *ferrum*, in the shape of *Basham's mixture*, until albumin disappears and health is restored. The following is the formula of Basham's mixture:—

Rx.	Liq. ammon. acetat.,	fʒ vj
	Acid acetic.,	fʒ iiij
	Tinct. ferri chlor.,	fʒ v
	Alcoholis,	fʒ ij
	Syrup.,	fʒ iv
	Aquæ,	fʒ iv.
M.		

SIG.—Dose, fʒ j-fʒ j.

## CHRONIC PARENCHYMATOUS NEPHRITIS.

**Synonyms.** Chronic Bright's disease; chronic tubal nephritis; chronic albuminuria; large white kidney.

**Definition.** A chronic inflammation of the cortical and tubular structure of the kidneys; characterized by albuminous urine, dropsy, increasing anæmia, with attacks of *acute uræmia*.

**Causes.** Occasionally follows the acute form; syphilis; chronic malaria; chronic alcoholism; chronic mercurialism; lead poisoning; protracted suppuration; some undetermined nervous condition.

It is a disease of the young, rarely occurring after forty.

**Pathological Anatomy.** A large white, or yellowish-white, smooth kidney often twice the normal size. The capsule is nowhere adherent to the organ. Upon section, considerable tumefaction of the cortical substance and the rarity of vascular striæ are recognized. The medullary substance shows no appreciable alteration, its color being normal. The convoluted tubes are irregularly dilated and thickened, and filled with broken-down, granulated epithelium and fibrinous casts. In pronounced cases there is fatty degeneration of the tubular epithelium.

"The intertubular matrix is greatly thickened—a change due to hyperplasia of the connective-tissue elements, to the migration of the white corpuscles and their subsequent multiplication and fatty transformation, and to a quantity of fluid exudation, the product of the increased pressure in the veins."

**Symptoms.** The onset is gradual and insidious, and the affection is seldom recognized until the appearance of *dropsy*, which, beginning under the eyes and in the face, extends all over the body, causing *dyspnœa* from *ascites* or *hydrothorax*, although in many cases the dropsy is a late symptom, the patient becoming *pale*, *debilitated* and suffering from *cardiac palpitation*, increasing *dyspnœa*, and *vomiting*, all gradually developing without apparent cause; also *headache*, *vertigo* and *defective vision*. The *urine* is scanty, high-colored, *albuminous*, and under the microscope showing hyaline and granular *tube casts*, granular epithelium, and if fatty degeneration occur, *fatty tube casts* and oil globules. The increase above the normal amount of the urine as the disease progresses must not be forgotten, when the specific gravity is low, 1.010–1.015, and the quantity of albumin is increased. Irritable bladder is a very constant symptom.

*Anæmia* is pronounced, from the large waste of albumin. *Gastro-intestinal* disorders and vague *neuralgic pains* are common occurrences. *Cardiac hypertrophy* is of common occurrence. *Bronchial catarrh*, with slight *œdema of the larynx*, causing *husky voice*, are frequent complications. *Amaurosis*, the result of *neuro-retinitis*, occurs in a greater or less degree in all pronounced cases. *Uræmic symptoms* occur, and especially *uræmic asthma* (renal asthma).

**Complications.** Pneumonitis, pleuritis, pericarditis, peritonitis, meningitis, and cardiac hypertrophy.

**Prognosis.** Not unfavorable, unless urine persistently contains a large number of *fatty tube casts* and *oil globules*. Relapses are frequent, but many complete (?) recoveries are recorded. I have seen four apparent recoveries, one after twelve months' duration, another after two years' duration, and still another after five years' duration, no return showing itself after two years.

**Treatment.** It is to be borne in mind that the course of a case of chronic Bright's disease is not continuously downward; periods of remission often follow the most aggravated symptoms, the patient and his friends being buoyed into the hope of an early and complete recovery, when, as suddenly, an attack of acute uræmia terminates life.

*Rest and diet* are important elements in the treatment.

A patient with chronic Bright's disease should, as far as possible, be relieved from all cares of business and spend a goodly portion of time in bed.

The *diet* should be entirely, or as nearly so as possible, a *milk diet*, the daily amount used being from two to four quarts. The moderate use of a light wine is at times of advantage if taken with the food, although a fair number of cases do better without stimulants.

The use of *diaphoretics* and *hydragogue cathartics* are only indicated when the dropsy is marked, the skin harsh and dry, the urinary secretion scanty and uræmic symptoms are threatening, for which administer the following :—

<b>R.</b> Hydrargyri chlor. mite, Pulv. scillæ, Pulv. digital., . . . . .    aa . . . . . gr. j. Et ft. pil.	M.
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**SIG.—**Three times daily for a few days.

*Diuresis* should be promoted, if the secretion is small, by *digitalis*,

*caffein* or *arbutin* internally, and dry cups and poultices over the loins.

*Iron* is preëminently the drug for this variety of Bright's disease, the *tinctura ferri chloridum* the best form for administration.

The *anæmia* is to be treated by *oleum morrhuae*, *arsenicum* and *ferrum*, an excellent formula for the latter being—

R.	Strychninæ sulph., . . . . .	gr. $\frac{1}{4}$
	Tinct. ferri chloridi, . . . . .	f $\frac{2}{3}$ ss
	Acidi aceticæ puræ, . . . . .	f $\frac{2}{3}$ iss
	Curacoæ alba, . . . . .	f $\frac{2}{3}$ j
	Liq. ammonii acetat., . . . . ad . . .	f $\frac{2}{3}$ vj.
		M.

SIG.—Tablespoonful every five hours, followed by a glass of cold water.

Another good formula is—

R.	Hydrargyri chlor. corrosiv., . . . . .	gr. j
	Aurii et sodii chloridi, . . . . .	gr. j
	Ferri per hydrogen, . . . . .	gr. xxiv.
	Ft. pil. xxiv.	M.

SIG.—A pill after meals.

To check the waste of *albumin*, a difficult matter, the following remedies have been used with more or less success: *ergota*, *quinina*, *acidum gallicum*, *acidum benzoicum*, *tinctura cantharidis*, *potassii iodidum*, and, lastly, the Russian remedy, *blatta orientalis* (cockroach).

For *dropsy*, purgatives, such as *pulvis jalapæ compositus*, *hydragogue cathartics* and alkaline mineral waters; act on skin with *vapor baths*, or *pilocarpus muriat.* gr.  $\frac{1}{8}$ , repeated if not much cardiac depression, or combining *pulvis ipecacuanhæ et opii* gr. iij with *potassii nitras* gr. iij-v every two or three hours. If there be great distention of the serous cavities, interfering with the respiration, the *aspirator* should be used. Puncture of the skin may be necessary at times, and is well accomplished with an ordinary cambric needle.

Cases due to *syphilis*, if the loss of renal structure is slight, are cured by a course of *hydrargyri corrosivum chloridum* and *potassii iodidum* with *oleum morrhuae*.

## INTERSTITIAL NEPHRITIS.

**Synonyms.** Chronic Bright's disease; sclerosis of the kidneys contracted kidneys; small red kidney; gouty kidney.

**Definition.** An inflammation of the intervening connective tissue of the kidney, chronic in its progress, resulting in an induration or hardening, with contraction of the organ; characterized by frequent passing of large amounts of pale, albuminous urine, of low specific gravity, disorders of the gastro-intestinal and nervous systems, and a strong tendency to cardiac hypertrophy and changes in the vessels.

**Causes.** A disease of middle life, from forty to sixty years. Gout a very common cause; lead cachexia; syphilis; alcoholism; long-continued worry, anxiety or grief; alterations in the renal ganglionic centres (DaCosta and Longstreh).

**Pathological Anatomy.** The kidneys are reduced in size. The *capsule* is thickened, opaque and adherent. The *surface* of the kidney is granular, with cysts of various sizes, of transparent color, irregularly over the surface. On section the *tissue* of the kidney is tough and resistant. The *cortical* portion is thin, from atrophy, being only a line or two in thickness. The *connective tissue* is greatly thickened, compressing the tubules into mere threads, the *glomeruli* being grouped together in bunches, owing to the wasting of the intermediate tubes. The *color* varies, from a darkish-brown to a yellowish-gray, according to the amount of blood in the organ.

The left side of the *heart* is hypertrophied, and there is also hypertrophy of the muscular fibre of the *arterioles* throughout the body; if the case is protracted the hypertrophied tissues undergo fatty degeneration.

In many cases there occur fatty degeneration of the retinal tissues, or sclerosis of the nerve-fibre layer, changes which are termed *retinitis albuminuria*.

The "ganglionic centres" undergo fatty degeneration and atrophy (DaCosta and Longstreh).

*Apoplexy* is a frequent termination of interstitial nephritis, the rupture of a cerebral vessel suggesting it to be a disease of degeneration.

**Symptoms.** Onset insidious, and often marked alterations in the kidneys, heart and vessels have occurred before the disease is recognized. There are no characteristic early symptoms in the

majority of cases, the disease being apparently latent, until some special outbreak cause a more thorough examination of patient, when he is found to have an interstitial nephritis.

Any of the following symptoms may first attract attention, to wit: *frequent micturition, increased amount of urine, of a pale color, containing a small amount of albumin, which may be absent for days, occasional epithelial cells and hyaline casts.* No dropsy, but a little *puffiness and œdema of the conjunctiva—the Bright's eye.* *Disorders of vision.* *Forcible cardiac action with high arterial tension.* And any of the following symptoms, the result of *uræmia*: Persistent *dyspepsia, occasional vomiting, regardless of food; headache, vertigo and stupor, or drowsiness; violent itching of the skin; tremors, convulsions, epileptic seizures, or apoplectic attacks.*

The body weight declines, the skin is dry and scurfy, the strength fails, and shortness of breath on exertion is present.

The *termination* is usually by convulsions, coma and death.

**Complications.** Bronchitis; pneumonia; pleuritis; pericarditis; cardiac hypertrophy.

**Diagnosis.** Differs from *parenchymatous nephritis* in the following: large quantity of urine, clear, of low specific gravity, small amount of albumin, with few hyaline casts; the hypertrophied heart and tense arteries and marked disorders of vision.

**Prognosis.** Pursues a very chronic course; cases recorded under observation eleven years; but the termination is always fatal.

**Treatment.** Regulated diet. Diaphoretics. Diuretics. Avoid alcoholic stimulants. As nearly absolute rest as patient's general health will permit.

To prevent the growth of the connective tissue, the following remedies are recommended, to wit: *potassii iodidum, hydrargyri corrosivum chloridum, gr.  $\frac{1}{20}$ , aurii et sodii chloridum, gr.  $\frac{1}{20}$ , ferri iodidum and arsenicum.*

For *uræmia*, if patient is conscious, *purgatives, diaphoretics and diuretics.* If unconscious, *morphina hypodermically or chloroform inhalations.*

### AMYLOID KIDNEY.

**Synonyms.** Chronic Bright's disease; waxy kidney; lardaceous kidney.

**Definition.** A peculiar infiltration into, or a degeneration of,

the structure of the kidney, from the deposit of an albuminoid material, having a superficial resemblance to starch granules. Similar changes occur in the liver, spleen, intestines, and other organs.

**Causes.** The chief cause is prolonged suppuration, especially of the bones; coxalgia; syphilis; cancer.

**Pathological Anatomy.** The kidney is uniformly enlarged. It presents a pale, glistening, translucent appearance, and has a doughy consistency. On section, the surface is homogeneous, anaemic and whitish. The deposit occurs along the renal vessels and in the vascular tufts of the glomeruli, progressing until all parts of the organ are infiltrated. When the organ is thus infiltrated, the proper structure undergoes an atrophic degeneration, the result of pressure.

The reaction with iodine and sulphuric acid affords a certain test of the *amyloid* deposit. Brush over a section of the affected kidney a solution of iodine with iodide of potassium in water, when a mahogany color will be produced, and if diluted sulphuric acid is now added, a violet or bluish tint results. A very pretty reaction is to take a one per cent. solution of anilin violet, which strikes a red or pink color with the amyloid material, while the unaltered tissues are stained blue, making a beautiful contrast.

Similar changes occur in other organs of the body. With the amyloid change may be associated either parenchymatous or interstitial nephritis.

**Symptoms.** Associated with *wasting* are *œdema* of the lower extremities and *ascites*, with an *increased flow of urine*, pale, watery and of low specific gravity, containing *albumin* and *hyaline casts* which are transparent. If the amyloid change be associated with other forms of renal change, the urine will show the characteristics of such condition. A profuse, watery and persistent *diarrhœa* adds to the suffering, caused by amyloid changes in the intestinal canal.

**Diagnosis.** Differs from *parenchymatous nephritis* in its clinical history, and the fact of its always being associated with a suppurating disease.

From *interstitial nephritis*, in its history, character of the urine, *absence* of *uræmia*, cardiac hypertrophy, changes in the vessels, and the fact of its association with suppurating diseases and similar changes in other organs.

**Prognosis.** Controlled by the suppurating disease with which it

is associated; the termination, when the amyloid change is fully developed, is unfavorable, death occurring within a few months, or under favorable conditions, not for one or more years.

**Treatment.** Sustaining and symptomatic in character. Generous diet, and the persistent use of *ferri iodidum*, alternating with *ammonii murias* and *oleum morrhuae*.

If caused by syphilis, a thorough course of *potassii iodidum*, *ferri iodidum* and *hydrargyri corrosivum chloridum*, with *oleum morrhuae*.

### PYELITIS.

**Synonyms.** Suppurative nephritis; pyelo-nephritis.

**Definition.** An acute catarrhal inflammation of the pelvis of the kidney; the term *pyelo-nephritis* is used when suppurative inflammation is superadded to the catarrhal inflammation. The disease is characterized by lumbar pains, irritability of the bladder, the urine neutral, or alkaline in reaction, and milky in appearance; if *pyelo-nephritis* occur, symptoms of hectic fever and exhaustion are added, the urine containing pus.

**Causes.** Cold, or exposure; cystitis; obstruction of the ureters by renal calculi; pressure from a tumor; abuse of certain drugs; rheumatism; sequelæ of infectious diseases.

**Pathological Anatomy.** The inflammation is *catarrhal*; it is characterized by injection of the mucous membrane of the pelvis of the kidney, with slight extravasations of blood; relaxation and softening, shedding of the epithelium, and the subsequent discharge of mucus and pus. If the morbid condition has existed for some time, the kidneys, one or both, are in a process of suppuration, they are enlarged, deeply congested, except where suppuration is proceeding, when they are of a yellowish-white color—*pyelo-nephritis*. Pus is constantly forming, and, if there be no obstruction, flows away with the urine; should there be an impediment to its escape, pus accumulates in the pelvis of the kidney, causing its distention, giving rise to the condition known as *pyelo-nephrosis*. The pressure caused by the obstruction finally leads to destruction of the entire organ, a mere sac, or *renal cyst* remaining.

**Symptoms.** If caused by *cystitis*, symptoms of this condition occur first; if from *renal calculi*, its characteristic symptoms precede those of pyelitis.

Begins by *chilliness, feverishness, lumbar pains* following the course of the ureters, *frequent micturition*, the urine *milky* in appearance when voided, *acid or neutral* in reaction, and depositing a copious sediment, whitish or yellowish-white in color, containing only a small amount of albumin, no more than is due to the *pus*.

Cases of pyelitis due to renal calculi frequently show *hemorrhages*; the bloody urine after some extra exertion.

If *pyelo-nephritis* follow, symptoms of pyæmia supervene, to wit: *fever, typhoid* in character, low, muttering *delirium, subsultus tendinum, stupor*, decline in strength, and loss of flesh, with perhaps a *tumor* in the lumbar region.

If both kidneys are affected *uræmic* symptoms are frequent.

**Diagnosis.** From *cystitis*, by history, lumbar pains and *acidity* of purulent urine, the urine in *cystitis* being always *alkaline*. A microscopical examination of the urine will aid the diagnosis very much.

*Peri-nephritis*, a disease of loose tissue, around about the kidneys, terminating in abscess, causing lumbar pain, increased by motion or pressure, hectic fever, sense of fluctuation over kidneys, the *urine remaining normal*.

**Prognosis.** Simple cases, where no obstruction to flow of pus, *recover* in a week or ten days. If obstruction of the ureter, the prognosis is grave. Suppurative cases unfavorable.

**Treatment.** Rest in bed. Milk diet. Free use of water to dilute the urine, and free diaphoresis. *Quinina* to keep down temperature, prevent formation of pus, and maintain the powers of life.

To change the character of the secretion, Prof. Da Costa strongly recommends *pix liquida*; other remedies are *oleum santali, copaiba, eucalyptol, terebinthina* and *cubeba*. I have seen excellent results from a prolonged course of the Buffalo Lithia Springs water or the Rockbridge Alum Springs water of Virginia.

For renal hemorrhage, *alumen*, gr. xx, repeated p. r. n., is successful.

If *abscess* results, *aspiration, quinina* and *stimulants*. Extirpation of the diseased kidney has been followed with fair health.

## ACUTE URÆMIA.

**Synonyms.** Uræmic poisoning ; uræmic intoxication ; uræmic coma ; uræmic convulsions.

**Definition.** A group of nervous phenomena, which occasionally develop during the course of acute or chronic Bright's disease, and other maladies, the result of the retention or accumulation in the blood of an excrementitious material, supposed to be *urea* ; the flow of urine being either normal, lessened or increased.

**Causes.** Suppression of urine, from acute or chronic Bright's disease ; cystic, tubercular or cancerous kidney ; the puerperal state ; operations on the uterus, bladder, urethra or rectum.

**Symptoms.** Uræmic intoxication is the result of the failure of the kidneys to perform their normal function of eliminating some one or all of the poisonous elements of the urine.

The toxæmia may develop suddenly, by a *convulsive* seizure followed by *coma*, or slowly and gradually. Usually the attack is preceded by a decrease in the urinary secretion ; although it must be borne in mind that in rare instances, during, or immediately prior to, the appearance of the uræmic phenomena, the normal urinary flow has been largely exceeded.

The onset is usually with *headache*, *dimness of vision*, dilated, sluggish pupils, *drowsiness*, *vertigo*, *deafness*, dusky countenance, *nausea*, *vomiting*, and either a *chill* followed by *fever*, or a *cool skin* from the onset ; the *mind is dull*, deepening into *stupor*, to be followed by *coma*, or *convulsions* precede the coma, which terminates in death, unless the poison causing the attack is rapidly eliminated. If the amount of accumulated urea is small the phenomena may not approach the pronounced coma described, the patient being able to be aroused. When *convulsions* occur they rapidly succeed one another, consciousness seldom being complete between the fits.

**Diagnosis.** *Cerebral apoplexy* may be mistaken for uræmic coma, or the reverse. The chief points of distinction are, in the latter the attack is usually in patients suffering from dropsy, and that the coma is not sudden in its appearance, but is generally preceded by other nervous phenomena, such as headache, vertigo, dimness of vision, obstinate vomiting, and convulsions. Again, the *uræmic stertor* is a sharp, hissing sound, while that of apoplexy is "snoring." Apoplexy is followed by paralysis, uræmic coma is not.

An *epileptic* seizure is preceded by the sharp cry and extreme

pallor of the face, the countenance being dusky in uræmic convulsions.

**Prognosis.** An attack of acute uræmia is always a very grave condition. The prognosis depends upon the amount of retained poison, the length of time it has been retained, and the condition of the organs of elimination.

**Treatment.** The indications in acute uræmia are: *first*, to arrest the nervous phenomena; *secondly*, to promote elimination. Prof. Loomis has succeeded in meeting both of these indications by hypodermic injections of *morphina*, gr.  $\frac{1}{6}$ - $\frac{1}{4}$ - $\frac{1}{2}$ , repeated, if required, every two hours. He says, "the most uniform effect of morphine so administered is, first, to arrest muscular spasms; second, to establish profuse diaphoresis; third, to facilitate the action of cathartics and diuretics, especially, the diuretic action of *digitalis*."

Following the injection of *morphina*, *diaphoresis* should be promoted by means of the *vapor-bath*, or the *hot wet-pack*, or the hypodermic use of *pilocarpinæ hydrochloras*, gr.  $\frac{1}{2}$ - $\frac{1}{6}$ - $\frac{1}{4}$ , provided no counter-indication to its use exists, or frequent doses of *caffeina*.

The *convulsive* phenomena are rapidly controlled by inhalations of *chloroformum*, or the internal or rectal administration of *chloral*.

*Diuresis* should be promoted by *infusum digitalis*, and *dry* or *wet cupping*, and poultices over the loins.

*Catharsis* is best produced by *elaterium*, gr.  $\frac{1}{2}$ - $\frac{1}{8}$ .

For warding off attacks of uræmia, good results follow the use of *acidum benzoicum*, *acidum nitricum dilutum*, or *acidum hydrochloricum dilutum* in small, frequently repeated doses.

## RENAL CALCULI.

**Synonyms.** Nephro-lithiasis; gravel; renal colic.

**Definition.** *Renal calculi* are concretions formed by the precipitation of certain substances from the urine, around some body or substance acting as a nucleus.

Their presence may not be recognized until one or more attempt to pass along the ureters, when an attack of *renal colic* results; or, by irritation, *pyelitis* is produced; or more rarely, they are voided by the urine without exciting any symptoms.

By *gravel* is meant very small concretions, which are often passed in the urine in large numbers.

**Causes.** Occur at all ages; frequent before the fifth year, and from five to fifteen. Males are more liable than females. A special liability seems to exist in some families, but the precise etiology of calculi is not yet determined.

**Varieties.** 1. *Uric acid*, as calculi and gravel, and especially associated with the gouty diathesis.

2. *Urates*, chiefly urate of ammonia; nearly always in childhood.

3. *Oxalate of lime* or mulberry calculus; characterized by hardness, roughness and very dark color.

4. *Phosphatic calculi* form as frequently in the bladder as in the kidney, and present a chalky or earthy appearance.

5. *Alternating calculi*, consisting of alternate layers of two or more primary deposits.

**Anatomical Characters.** In structure, a urinary calculus usually consists of a *central nucleus*, surrounded by the *body*, and outside of all there may be a *phosphatic crust*. The nucleus may or may not be of the same material as the rest of the stone, sometimes being a foreign body, mucus or blood.

A section generally shows a *stratified* arrangement, or it may be partly or completely *radiated*.

**Symptoms.** The clinical signs of renal calculi are those consequent on the results of their presence, to wit: *renal hemorrhage*, *renal congestion*, *inflammation*, terminating in *abscess*, *pyelitis*, or *pyelo-nephritis*, *cystitis* or *renal colic*.

The symptoms of *renal colic* begin abruptly, by severe, agonizing *pain* in the lumbar region, following the ureters into the corresponding groin and thigh. *Pain* and *retraction* of corresponding testicle, also of glans penis. *Face pale* and *features pinched*, the surface cold and damp. Irritability of the bladder, the urine passed in drops containing some blood. So severe is the pain at times that the patient may faint or pass into unconsciousness, or have a general convulsion. If both ureters are obstructed, *uræmic symptoms* will arise.

The paroxysm usually terminates suddenly after some minutes or hours, the stone escaping into the bladder.

**Prognosis.** Renal calculus is attended with many dangers. It may produce extensive disorganization of the kidneys, or its passage along the ureter may prove fatal. If the stone be very large, or if more than one, the prognosis is graver. Calculus is a disease very

apt to recur. Renal sand (*gravel*) and small concretions may, after more or less delay be voided with the urine.

**Treatment.** An attack of *renal colic* is best relieved by a hypodermic injection of *morphina* and *atropina*, and a warm bath or a suppository of *ext. opii*, gr. j, *ext. belladonnæ alco.*, gr. ss, repeated if needed.

For attacks of *gravel*, *liquor potassii citratis*, fʒ ss, every three hours, and, if much *vesical irritability*, adding *tinct. opii camph.*, fʒ ss-j.

For *renal hemorrhage*, Prof. Bartholow reports success with

R. Extracti ergotæ fluidi,  
Tincturæ krameriæ, . . . . . aa . . . . . ʒ ij. M.  
SIG.—ʒ j every two or more hours.

I have always successfully controlled renal hemorrhages with twenty-grain doses of *alumen*, repeated p. r. n.

For *uric acid calculi*, as a solvent, Buffalo Lithia Springs Water or the Rockbridge Alum Springs Water of Virginia, or *potassii tartraborates*, "obtained by heating together four parts of cream of tartar, one part of boracic acid, and ten parts of water. A scruple may be given three or four times a day, in water, largely diluted."

For *phosphatic calculi*, as a solvent, *ammonii benzoas*, well diluted and long continued.

## CYSTITIS.

**Synonym.** Catarrh of the bladder.

**Definition.** An inflammation of the mucous membrane lining the urinary bladder, acute or chronic in its course, and of either a catarrhal, croupous or diphtheritic character; characterized by rigors, moderate fever, hypogastric pain, frequent but scanty micturition and severe vesical tenesmus, the urine containing pus.

**Causes.** *Acute variety*; long retention of urine; foreign bodies in the bladder; pyelitis; urethritis; blows over the pubes; myelitis, and secondary to fevers or diphtheria. *Chronic variety*; following the acute variety; retention the result of enlarged prostate or an urethral stricture; calculi; gout; chronic Bright's disease.

**Pathological Anatomy.** In *acute catarrhal cystitis*, there first ensues hyperæmia of the mucous membrane of the entire or a portion of the bladder, manifested by redness, swelling and oedema;

followed by an increased secretion of the small glands at the base of the bladder, and an increased growth and consequent desquamation of the vesical epithelium, together with a copious generation of young cells; if the hyperæmia be decided, rupture of the capillaries and extravasation of blood occur.

If the inflammation be intense suppuration of the sub-mucous connective tissue may result, and ulceration of the mucous membrane permit the sub-mucous abscesses to empty into the bladder.

If the inflammation be of a croupous or diphtheritic character, the morbid anatomy does not differ from the same variety of inflammations in other mucous membranes.

In *chronic cystitis* "the mucous membrane is thick, blue-gray in color, and very tough. Muco-pus and viscid mucus are formed in large quantities upon its surface. The muscular wall of the bladder may sometimes be half an inch thick, and the fasciculi give a ribbed appearance to the internal surface, called the 'columnar bladder.' The hypertrophy of chronic cystitis may be eccentric or concentric. In some cases diverticuli are formed, in whose walls are dilated and tortuous veins. In nearly all cases bacteria are found in abundance." (Loomis.)

**Symptoms.** *Acute cystitis*; the onset is usually abrupt, by *rigors*, slight *fever*, loss of appetite, sleeplessness, a feeling of depression; *frequent micturition*, but the *urine* is only voided drop by drop, its passage followed by distressing *vesical tenesmus*, the result of spasm of the bladder; *pain* over the pubis and in the iliac regions, of a dull character, at times becoming sharp and agonizing; *burning along the urethra* adds to the distress of the patient.

The *urine* is cloudy, of an *alkaline* reaction, and at times is *fetid*, the microscope showing *epithelium, pus* and *red blood corpuscles*.

*Chronic cystitis*; the onset is gradual and insidious, and is excited by some obstacle to the evacuation of the urine, such as stricture, the presence of a stone in the bladder, or enlargement of the prostate gland. There are present dull *pain*, *frequent* but *scanty micturition*, the *urine* is *alkaline*, containing large amounts of *muco-pus* or *pus*; on standing, it deposits a thick, glairy, viscid sediment, in which, under the microscope, triple phosphates and large pus corpuscles, extremely regular both in contents and in shape, may be detected.

Although the quantity of urine voided by the patient is small, yet

if immediately after micturition the catheter is used, several ounces of *fetid, cloudy, alkaline urine* may be removed.

Patients with chronic cystitis usually present decided constitutional debility.

Severe local pain, emaciation and occasional bloody urine, indicate ulceration of the vesical mucous membrane.

**Diagnosis.** *Pyelitis* has lumbar pains following the course of the ureters, frequent micturition without the severe vesical tenesmus; the urine, although cloudy, has an acid or neutral reaction.

**Prognosis.** The *acute variety* is, as a rule, good, being controlled by the cause.

The *chronic variety* continues for years, and after hypertrophy of the bladder is incurable.

**Treatment.** Rest is paramount. The diet must be restricted, all highly-seasoned articles being particularly interdicted; milk is the most suitable diet.

Warm applications over the pubic region are of benefit; and leeching and cupping over the bladder are of service.

The urine should be well diluted by large draughts of pure water and particularly the alkaline mineral waters, to wit: Farmville lithia, Buffalo lithia or the Rockbridge alum, or Vichy waters. The following formulæ are of decided benefit:—

R. Acidi benzoici,  
Sodii borat, . . . . . ää . . . . . ʒ ij  
Infusi buchu, vel  
Infusi uvæ ursæ, . . . . . f ʒ vj. M.

SIG.—Tablespoonful every 2 hours, well diluted.

Or—

R. Liquor. potassæ, . . . . . f ʒ iij  
Mucil. acaciæ, . . . . . ad . . . . . f ʒ viij. M.  
SIG.—Tablespoonful every 4 hours, well diluted.

For the *pain* and *tenesmus* relief is afforded by a suppository of *extractum opii* and *extractum belladonnæ*, repeated as needed.

The *vesical tenesmus* is often benefited by *extractum cannabis indica fluidum*, f ʒ ss, every three or four hours.

*Chronic cystitis.* The bladder should be completely emptied with the catheter several times in the twenty-four hours.

The use of *eucalyptol*, gtt. x-xv, every four hours, well diluted, or a good preparation of *tar*, or *extractum grindeliæ fluidum*, mxx-f ʒ j,

three or four times daily, and washing out the bladder with the following mixture, has been of decided benefit in the hands of the author :—

R.	Sodii borat., . . . . .	$\frac{3}{2}$ j.	
	Glycerini, . . . . .	$\frac{3}{2}$ ij.	
	Aqua, . . . . .	$\frac{3}{2}$ ij.	M.

SIG.—f  $\frac{3}{2}$  ss-iss added to warm water and injected into the bladder once or twice daily.

The diet should be nutritious, but without spices of any kind. The free use of the alkaline mineral waters is of advantage.

### MOVABLE KIDNEY.

**Synonym.** Floating kidney; wandering kidney; ectopia renis.

**Definition.** A condition of the kidney, either congenital or acquired, in which the tissues around about the organ are so lax and the renal vessels so elongated as to permit the kidney to be moved in certain directions, causing a movable tumor in the abdomen.

**Causes.** The kidney is normally held in position by the layer of peritoneum which is attached to the anterior surface of its adipose capsule. In movable kidney, the adipose tissue in which the normal kidney is imbedded partly or wholly disappears.

The renal vessels are in many cases abnormally long. Relaxation of the abdominal walls from pregnancy or other causes. The use of tight corsets or girdles about the waist; violence; increased weight of the organ from disease; the pressure of tumors growing in the neighborhood of the kidney; the traction of hernias.

The condition may be congenital or acquired, more frequently the latter. It is far more frequent in women than in men.

**Symptoms.** Floating kidney may and often does exist without any noticeable symptoms, the condition being unknown until accidentally discovered by the physician while making a physical examination of the abdomen.

As a rule, however, patients experience a heavy, dragging pain in the abdomen, aggravated when walking or standing. There are also present gastro-intestinal symptoms, more or less constant, with melancholia aggravated by the mental anxiety the presence of a *tumor* in the abdomen causes the patient, in spite of the assurances of the physician, that it is not a cancer.

At times, from some unknown or unrecognized cause, the movable kidney swells and becomes very sensitive to the touch, and migrates a considerable distance from its normal position. Such an occurrence aggravates all the former symptoms mentioned. This condition has been ascribed to a twisting of the ureter and consequent retention of the urine in the pelvis of the kidney, or to a localized peritonitis or to a partial strangulation of the kidney from compression or twisting of its blood vessels.

*Hysterical* symptoms are frequently observed in women suffering from wandering kidney.

**Diagnosis.** The dislocation of the kidney is to be recollected in determining the nature of obscure tumors within the abdomen.

The late Prof. Austin Flint based the recognition of this variety of abdominal tumor on the following diagnostic points: "It is situated in the hypochondriac region. It has the size and shape of the normal kidney, and this may be determinable by palpation, which is most advantageously employed by placing one hand over the lumbar region and the other in front on the abdominal walls, and then making counter-pressure from one hand to the other. It is generally movable, and in some cases the organ can be restored to its proper situation."

Other tumors are to be excluded by the absence of their diagnostic characters.

**Prognosis.** It is a rare occurrence to have a fatal termination from movable kidney *per se*.

**Treatment.** Symptomatic. It is said that some of the inconvenience and sometimes suffering attending movable kidney may be lessened by means of an abdominal bandage, belt or supporter.

If attacks of pain and swelling occur, the patient should be placed in bed, hot applications over the abdomen, the use of opiates and attempts at replacing the organ.

Extirpation of a movable kidney has been successfully performed a number of times.

Nephroraphy, an operation for fixation of the kidney by means of sutures, has been devised.

## ACUTE GENERAL DISEASES.

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### PAROTIDITIS.

**Synonym.** Mumps.

**Definition.** An acute specific *infectious* inflammation of one or both parotid and other salivary glands and the surrounding connective tissue, with a very strong tendency to migrate into the mammae or testes ; characterized by pain, swelling and disordered function of the glands.

**Causes.** A specific poison. Contagious. Occurs in epidemics, although isolated cases are seen. Males more liable than females. The most common ages between five years and puberty. As a rule, it occurs but once in the same individual.

The *period of incubation* is from two to three weeks.

**Pathological Anatomy.** There is inflammation of one or both parotid glands, and in severe epidemics the cellular tissue pervading the gland is involved.

The catarrhal inflammation begins in the gland ducts and rapidly extends to the gland proper. There is congestion, swelling and an infiltration of serous fluid, with more or less infiltration of the adjacent tissues. The swelling may suddenly reach an enormous size and as suddenly decline, the gland returning to its normal condition, or, rarely, an abscess results, with partial or complete destruction of the gland. Occasionally the submaxillary gland is involved, also the mammae and testes.

*Metastatic parotiditis* occurs secondary to severe blood poisoning, as in pyæmia, typhoid or typhus fevers or diphtheria. The usual termination of secondary parotiditis is by suppuration and destruction of gland structure.

**Symptoms.** The onset is rather sudden, by *malaise, chill, fever, 101°-103° F., quick pulse, headache, dry skin, scanty urine*, followed within a day or two by *stiffness at the angles of the jaw, swelling of the parotid and other salivary glands, pain, increased by moving the jaws, with general œdema of the affected side of the face, at times the skin being reddened*. *Salivation* is frequent, and occasionally deafness occurs.

The swelling and other glandular symptoms subside about the

sixth or seventh day, to be followed by restoration to health, or what is more common, the involvement of the opposite gland.

At any time during the disease *metastasis* to the *mammæ*, *ovaries*, or *testes* is apt to occur, when the symptoms peculiar to such affection will be added. It has been noted that a *continuance* of the *temperature* after the decline of the parotid symptoms has begun, usually is significant of *metastasis*. It is claimed that the involvement of other organs during the course of mumps is not an example of metastasis, but is a true transfer of the disease.

**Diagnosis.** An error seems impossible.

**Prognosis.** Simple mumps, favorable; the chief danger being from the altered function of the *mammæ*, *ovary* or *testes* after *metastasis*.

**Treatment.** The disease being self-limited, the indications are entirely symptomatic, with attention to the secretions, although *extractum pilocarpi fluidum*, M<sub>x</sub>-xxx repeated has been used with varying success as a specific.

*Locally*, either cold or warmth to the affected gland, whichever is most agreeable, or equal parts of *unguentum belladonnæ et hydrargyrum*.

If the swelling shows a tendency to linger, use small blisters over the part and administer *potassii iodidum*, if suppuration occur, evacuate pus, apply poultices and administer *quinina*.

If orchitis occur, the use of the belladonna and mercurial ointment and the internal use of *potassii iodidum*.

## DIPHTHERIA.

**Synonyms.** Putrid sore throat; malignant ulcerous sore throat; malignant quinsy; membranous angina.

**Definition.** An acute, specific, constitutional disease, both *epidemic* and *contagious*, beginning by an affection of the throat, characterized by a local exudation and glandular enlargements; attended with great prostration of the vital powers and albuminuria, and having for its sequelæ various paryses.

**Causes.** A specific poison, the character of which is unknown. It is preëminently a disease of childhood. It is apt to recur in those who have once been affected. All conditions of bad hygiene increase its virulence and diffusion, although the chief cause of its spread is *contagion*.

The poison exists in the exudation and secretions of the fauces and in the breath, and floats in the atmosphere at a considerable distance from the original source.

The theory of "No bacteria, no diphtheria," is not proven.

The *period of incubation* is from three to five days.

**Pathological Anatomy.** The *diphtheritic* inflammation differs from either the *croupous* or *catarrhal* form, in that the exudation is not only *upon*, but also *within*, the substance of the mucous membrane.

At first there is *redness*, which may begin in any part of the throat, associated with *swelling* and an *increased secretion* of viscid mucus. The redness spreads over the entire mucous surface, when the *exudation* makes its appearance. The deposit may commence from one or several points, such as one tonsil, the soft palate, or the back of the fauces, which, however, speedily extend and coalesce, forming extensive patches, or cover uniformly the entire surface.

The patches are of variable thickness, which is increased by successive layers being formed underneath.

The *color* is usually gray, white or slightly yellow, but may be brownish or blackish, the *consistence* ranging from "cream to wash leather."

On removing the membrane, which is accomplished with more or less difficulty, a raw bleeding surface is exposed, and at times an ulcer, which is speedily covered with a fresh deposit.

If the exudation separate itself, it is either not renewed at all or only in thinner films.

The exudation or membrane, examined by the microscope, is composed of fibrin, pus corpuscles, epithelial granular cells and bacteria.

If the *larynx*, *trachea*, or *nasal* mucous membranes participate in the disease, the *croupous* and not the *diphtheritic* form of inflammation occurs.

The *lymphatic glands* of the neck, whose vessels originate in the faucial tissues, are enlarged and inflamed, and contain large numbers of bacteria, probably originating as the result of decomposition.

The muscular tissue of the *heart* becomes soft, is easily torn, and its *fibrillæ* are far advanced in granular degeneration. Ulcerative *endocarditis* has been frequently observed.

The *kidneys* undergo a granular degeneration in severe attacks.

The *blood* undergoes alteration, being black and fluid.

**Symptoms.** Following the law of *contagious* diseases, the symptoms vary in intensity in different cases, the prominent symptoms being often disproportionate to the gravity of the attack.

The *invasion* may be *mild*, with *rigors* succeeded by moderate *fever, headache, languor, loss of appetite, stiffness of the neck, tenderness about the angles of the jaw, or slight soreness of the throat.*

In other cases the *invasion* is more *abrupt* and *severe*, with *chilliness* followed by great *febrile reaction, 103° to 105° F., pain in the ear, aching of the limbs, loss of strength, painful deglutition and swelling of the neck*, compelling the patient to take to bed from the onset.

The *appetite* is poor, the *tongue* slightly coated, sometimes more or less exudation appearing upon it, the *bowels* being either regular or slightly relaxed. The *pulse*, at first full and strong, soon becomes either frequent or slow, but *compressible*. The *urine* is scanty, high colored and contains *albumin*.

The *local symptoms* in the majority of cases are associated with the *throat*. The patient complains of a frequent and persistent desire to hawk, in order to clear the *throat*. On *inspection* the *fauces* are seen *red* and *swollen* and more or less covered with the diphtheritic *exudation*; sometimes the *tonsils* and *uvula* are greatly *swollen* and spotted with exudation. In bad cases, more or less *ulceration* or *sloughing* may be observed. Not unfrequently fragments of exudation, the *false membrane*, are expectorated, with particles of the ulcerated tissues, having an *offensive odor*, which is transmitted to the breath. The *lymphatic glands* of the *neck* are *enlarged* and *tender*, and in severe cases the tissues of the *neck* are greatly *tumefied*.

Extension to the *nasal cavities* causes a *sanguous* and *offensive* discharge from the nose, with attacks of *epistaxis*.

Extension to the *larynx* is indicated by *hoarseness* or *complete loss of voice*, *croupy cough* and *obstructive dyspnæa*, which often become *urgent*, the breathing being *noisy* and *stridulous*, and subject to *paroxysmal exacerbations*. If the inflammation extend to the *bronchi*, the breathing becomes still more embarrassed.

**Duration.** Ranges from two to fourteen days, an average being about nine days, although complications and sequelæ may prolong its course.

*Relapses* are not uncommon.

**Sequelæ.** Those who recover from a severe attack remain often

for weeks with a *pale* and *cachectic* appearance, due to the profound blood alteration.

*Paralysis* is a common sequelæ, following the mild as often as the severe attacks. Usually not occurring until the patient seems fully convalescent.

*Pharyngeal paralysis* is the most common, causing difficulty or inability of *deglutition*, fluids regurgitating through the nose.

*Cardiac paralysis* is not unfrequent, the pulsations descending to 60, 50, 40, and in a case seen by the author, to 20 per minute.

*Diphtheritic paralysis* may affect the motor muscles of the eye, causing *strabismus*; the muscles of one side, *hemiplegia*; of the legs, *paraplegia*; and of the bladder, leading to *retention of urine* or difficulty in passing it.

*Sensation* is also diminished in the paralyzed parts.

**Diagnosis.** From *follicular ulceration of the tonsils*, which is frequently termed diphtheria, by the slight or absent systemic symptoms, the ulcerated condition being limited to the tonsils, but often one, and the absence of glandular enlargement and following palsies.

From *pharyngitis*, by the absence of exudation and loss of faucial tissue and constitutional symptoms.

From *scarlatina*, by the presence of the eruption and the absence of membrane in the fauces.

From *membranous croup*, by the difference in the constitutional symptoms; croup appears sporadically and is not contagious, diphtheria being highly contagious and frequently occurs in epidemics; in diphtheria of the larynx, the depression is clearly that of blood poisoning, while in croup, the depression is in proportion to the mechanical obstruction of the respiration by the membranous exudation. The pathology of croup is simple and easy of investigation; diphtheria is obscure in its etiology and progress. The temperature record of croup is a high one until carbonic acid poisoning is imminent from the mechanical obstruction of respiration, while in diphtheria, the tendency to a decline in the temperature after the second day is nearly characteristic, regardless of the amount of laryngeal obstruction. In croup the pharynx contains no membrane, and is but slightly, if at all, inflamed, and associated trouble in the nose is of the rarest occurrence, the very reverse obtaining in diphtheria. In croup the laryngeal symptoms are from the onset, while in laryngeal diph-

theria the pharyngeal symptoms almost always precede. In croup glandular involvement is a clinical novelty, as are subsequent palsies, while glandular involvement and various palsies are the rule in diphtheria. Albuminuria is the rule in diphtheria, seldom occurring in croup.

**Prognosis.** Always grave, but more so in children than in adults. Its gravity, in the majority of cases, is proportionate to the local symptoms. The average mortality is about *ten per cent.*

*Favorable* indications are, moderate fever, strength slightly impaired, a good constitution, and moderate exudation.

*Unfavorable* indications are, great depression, spreading exudation, great swelling of the cervical glands, large amount of albumin, extension to larynx and nasal mucous membranes, hemorrhages from the fauces and nose, and an epidemic character.

**Treatment.** No specific plan of medication has been found uniformly successful. It is a disease of debility. The blood being more or less altered, it follows that *sustaining measures* should be resorted to in *all cases.*

The diet should be of the most nutritious character from the onset, with such articles as milk, eggs, broths and oysters, at intervals of every two or three hours. If deglutition be too painful, resort must be had to nutritious enemata, the following being a suitable formula:—

R.	Milk, . . . . .	fʒ j	
	Spts. frumenti; . . . . .	fʒ iv	
	Egg, . . . . .	One.	M.

SIG.—Little salt added, beaten up and warmed.

*Stimulants* should be used boldly from the onset, guiding the dose by the effect; usually, a child of two years requires from *thirty to sixty minims* of *spiritus vini gallici* or *spiritus frumenti*, every two or three hours; an adult from *two to four drachms* every three hours.

*Ferrum* and *potassii chloras*, in full doses, frequently repeated, have seemed, when begun early in the attack, to modify the course of the malady, and they have the additional advantage of acting locally upon the throat as they are swallowed. A good formula is—

R.	Tinct. ferri chlor., . . . . .	gtt. v-x-xx	
	Potassii chlor., . . . . .	gr. iij-v	
	Glycerini, . . . . .	fʒ ss	
	Syr. zingib., . . . . . ad	fʒ j-iij.	M.

SIG.—In water every three hours, for a child of two or three years.

The efficacy of the above is greatly enhanced, in the author's experience, by the addition to each dose of *tinctura belladonnæ*, gtt. j-v.

*Quinina*, gr. xv-j-xxiv per day for a young adult, and gr. v-x for a child, should be used throughout the disease; if irritability of the stomach prevent its administration by the mouth, it can be used as a *suppository* or locally in the form of the *oleate*.

*Calomel* in small doses, combined with *sodii bicarbonas* every hour until the *breath becomes fetid*, is beneficial, and especially in cases showing a tendency to spread toward the larynx. Indeed, a tolerance to calomel seems to exist in *diphtheria of the larynx*.

*Hydrarg. chlor. corros.*, gr.  $\frac{3}{8}$ - $\frac{1}{4}$ , repeated every second or third hour, also acts well in many cases, combined as follows:—

R.	Hydrargyri chlorid. corrosiv., . . . . .	gr. $\frac{1}{4}$	
	Tinct. ferri chlorid., . . . . .	m v-x	
	Glycerini, . . . . .	m x	
	Aquæ, . . . . . ad	3j.	M.
SIG.—	One teaspoonful every hour or two, well diluted.		

*Locally.* Cleanliness of the fauces is of the utmost importance, and if a *non-irritating disinfectant* be added, its value is enhanced. Prof. Bartholow "has seen excellent results from the frequent application of a solution of *acidum lacticum*, strong enough to taste sour, by means of a mop." The following, used as a *gargle*, or applied by a mop, is useful:—

R.	Acid. salicyl., . . . . .	gr. xx	
	Glycerini, . . . . .	f 3j	
	Aquæ destil., . . . . .	f 3 iiij.	M.

Or—

R.	Potass. chloras, . . . . .	3 iv	
	Acid. carbol., . . . . .	gr. ij-iv	
	Tinct. myrrh, . . . . .	3j.	
	Inf. cinchonæ, . . . . .	3 iiij.	M.

Or—

R.	Ext. pancreatis, . . . . .	3j.	
	Sodii bicarb., . . . . .	3 iiij.	

SIG.—Add 3j to aquæ 3vj, and apply with camel's-hair pencil.

*Inhalations* of steam and hot water, and allowing the patient to suck pellets of ice, give relief. Sponges dipped in hot water and applied to the angles of the jaw are beneficial.

For *laryngeal diphtheria* the same general treatment, especially the

*mercurial*, with *inhalations* of lime by slaking freshly-burned lime in a vessel and directing the vapor to the child by a newspaper, or some similar contrivance, or using three parts of *liquor calcis* and one part of *glycerin*, in an *atomizer*, every half hour or hour, or *liq. trypsin*, as a spray. If these means fail, resort must be had to *tracheotomy*, or *intubation of the larynx*, which have succeeded in many desperate cases.

For *nasal diphtheria*, the same general treatment, and syringing the nose every two or three hours with a weak solution *potassii chloras*, or *acidum carbolicum*, or the following :—

R.	Sodii sulphit., . . . . .	3 ij	
	Glycerini, . . . . .	f 3 ij	
	Aquæ, . . . . .	f 3 iv.	M.

For the *paralysis*, *strychnina* and *ferrum* internally, or *strychnina* hypodermically, with the *galvanic* or *faradic current* locally.

### ACUTE ARTICULAR RHEUMATISM.

**Synonyms.** Rheumatic fever; inflammatory rheumatism.

**Definition.** A constitutional disease, characterized by fever, inflammation in and around the joints, occurring in succession, and a great tendency to inflammation of either the endocardium or pericardium.

**Causes.** The *predisposing* causes are inherited tendency, scarlatina, and the puerperal state.

The *exciting* causes, exposure to cold and chilling of the body. Rheumatism rarely occurs before seven or after fifty years. The liability to the disease is increased by having had an attack.

**Pathological Anatomy.** The *blood* contains an excess of *lactic acid*. The *joints* bear the brunt of the attack; the synovial membrane is reddened, the vascularity of the synovial fringes is increased, so with the synovial fluid, which is thinner, of a reddish color, containing some gelatinous coagula of fibrin, and under the microscope nucleated cells, ordinary pus cells being rarely seen.

The swelling visible about the affected part depends mostly on inflammatory *oedema* of the connective tissue around the joint.

The *pain* is probably due, in all cases, to stretching of and pressure on the elements of the tissues by the dilated capillaries and the inflam-

matory œdema. For the changes which ensue when the endo- and peri-cardium are attacked, the reader is referred to the sections on those diseases.

**Symptoms.** Begins suddenly, generally at night, with a *chill* or chilliness, *pain* and *stiffness in the joints*, loss of appetite, at times, nausea and vomiting, followed by *fever*, the temperature soon reaching  $102^{\circ}$ , F., to  $104^{\circ}$ , in rare cases  $108^{\circ}$  to  $110^{\circ}$  (*the hyperpyrexia*), the *pulse* seldom exceeding 95, *great thirst*, *profuse acid sweats*, scanty, *high colored, acid urine*, at times showing traces of albumin, the *bowels constipated*. The *fever* continues throughout the attack, showing marked remissions. Delirium is absent, except the *hyperpyrexia* occur. *Sleep* is prevented by the *pain* and the *profuse perspirations*. The strength is moderately well preserved.

The skin is often covered with an eruption of *miliaria rubra*, *red papulae* and *miliaria alba*, the result of irritation at the orifices of the respiratory glands, from the excessive sweating.

The local phenomena are *pain*, *tenderness*, *increased heat*, *swelling* and *redness* of one or more joints; if but one joint, it is termed *monoarthritis*, if more than one, *polyarthritis*. *Pain* is aggravated by motion and *pressure*. *Swelling* is most apparent in those joints not covered with muscle, to wit: knee, wrist, elbow, ankle, and the hands and feet, and is proportionate to the acuteness of the attack. The inflammation may abruptly cease at one or more joints, and as suddenly attack others.

The disease is extremely irregular as regards the number of joints affected, although the local manifestations are controlled by an important pathological law, to wit: *the law of parallelism*. Corresponding joints are often affected together, and when not, the different affected joints are either on one side of the body or those on both sides which are analogous, as, the knee, elbow, wrist, ankle, hip, and shoulder, are attacked together.

**Complications.** Pericarditis, endocarditis, myocarditis, cerebral endarteritis, bronchitis, pneumonitis and pleuritis.

**Duration.** The duration of acute rheumatism is governed entirely by the presence or absence of complications. Uncomplicated cases recover in from *thirteen* to *twenty-one* days, although they may be prolonged to five or six weeks. Relapses are frequent.

**Diagnosis.** A typical case cannot be mistaken for any other

disease, but cases running a *subacute* course may be mistaken for acute rheumatoid arthritis, gonorrhœal rheumatism, or pyæmia.

*Acute rheumatoid arthritis* attacks one joint at a time and becomes permanent, has slight if any fever, no sweats or cardiac lesions.

*Gonorrhœal rheumatism* is associated with a gleety discharge, attacks either the ankle or wrist only, is slowly influenced by treatment, and lacks the febrile phenomena.

*Pyæmia* is usually manifested at a single joint at the time, and is followed by suppuration and all the symptoms of hectic fever.

**Prognosis.** Recovery is the rule in uncomplicated cases, the mortality being about three per cent. When death occurs it usually depends upon hyperpyrexia, cardiac complication, or cerebral endarteritis.

**Treatment.** Owing to our imperfect knowledge of the exact nature of this most painful disease, its treatment still remains either empirical or is directed toward certain prominent symptoms or complications of the disease. Garrod claims that "colored water" is about as potent as anything else, for it is, he says, a "self-limited disease," sometimes running a long and sometimes a short course. Rest in bed, whether the pain forces it or not, is imperative. *Warmth* is as imperative, for which purpose the patient should be kept in blankets—no sheets—and wear woolen garments. The *diet* should be easily digested food, milk being the most suitable.

Strong and vigorous patients do well with *acidum salicylicum* or the *salicylates* in large and frequently repeated doses, to wit:—

R.	Acidi salicylici, . . . . .	gr. xx
	Liq. ammonii acetat., . . . . .	fʒ iss
	Spts. ætheris nitrosi, . . . . .	mxx
	Syr. simplicis, . . . . .	m xv.

Every three hours, well diluted.

Or—

R.	Sodii salicyl., . . . . .	ʒ ij
	Sodii bicarb., . . . . .	ʒ iv
	Aq. menth. pip., . . . . .	fʒ ij
	Aq. destillat., . . . . .	fʒ ij.

M.

SIG.—One tablespoonful every three or four hours. Omit the soda as soon as urine becomes alkaline.

If benefit follows, the evidence is quickly afforded in the relief of pain

and the decline of the temperature and swelling. If, therefore, after three or four days' use of the salicylates or acidum salicylicum, as above recommended, signs of improvement are wanting, the treatment had better be changed for the *alkaline* treatment, which consists in the administration of *an ounce and a half* of the alkaline carbonates, either alone or with a vegetable acid, each twenty-four hours, until the *urine becomes neutral or alkaline*, when the quantity is reduced to an amount sufficient to maintain alkaline urine, to wit:—

R. Potassii bicarbonatis, . . . . . 3 ij  
 Acid. tartaric, . . . . . gr. xxx.

Dissolved in a glass of water and drank effervescing, every three hours.

Or—

R. Potass. bicarb., . . . . . 3 ij  
 Succi limonis, . . . . . f  $\frac{3}{2}$  iv  
 Aquæ cinnamomi, . . . . . ad . . . . . f  $\frac{3}{2}$  ss. M.

SIG.—In water, every three hours.

After the more *acute* symptoms are passed, change either of the above for *tinct. ferri chlor.*, gtt. xx every four hours, well diluted, or full doses of *Basham's* mixture.

Pale, feeble and anæmic patients, or attacks following scarlatina, are most favorably influenced with—

R. Tinct. ferri chlor., . . . . . gtt. xx-xxx  
 Syr. limonis, . . . . . git. xx  
 Aquæ, . . . . . ad . . . . . f  $\frac{3}{2}$  j. M.

SIG.—Every four hours, in glass of water.

Or—

R. Acid. salicylici, . . . . .  $\frac{3}{2}$  viij  
 Ferri pyrophos., . . . . .  $\frac{3}{2}$  iv  
 Sodii phosphat., . . . . .  $\frac{3}{2}$  iiij  
 Aquæ font., . . . . . f  $\frac{3}{2}$  ij. M.

SIG.—Dessertspoonful every three or four hours.

Prof. DaCosta reports a lessened proportion of *cardiac complications* with *ammonii bromidum*, gr. xv-xx, every four hours.

*Subacute* attacks and lingering cases are favorably influenced by

R. Lithii salicylatis, . . . . . gr. xv-xx  
 Syr. zingiberis, . . . . . f  $\frac{3}{2}$  j.  
 Aq. lauro-cerasi, . . . . . f  $\frac{3}{2}$  j. M.

Every four hours.

Good results follow, in a fair number of cases, *salol*, gr. v-x, every four hours, also from *antipyrine*, gr. xv, every three or four hours.

Whichever plan, acidum salicylicum, salicylates, alkaline or ferrum, is adopted, *quinina*, gr. xij-xx, per day, should also be used.

*Pain* and *restlessness* should be controlled by *opium* in some form, in full doses, or *atropina*, gr.  $\frac{1}{80}$ , hypodermically.

For the *hyperpyrexia*, *quinina*, gr. xxx-lx repeated p. r. n., with the *cold bath* or *wet pack*.

*Locally*, the affected joints should be wrapped in cotton-wool or flannel, saturated with a solution of *tinctura opii*, one part, and *liq. plumb. subacetat. dil.*, two parts, or—

R.	Sodii bicarbonatis, . . . . .	$\frac{3}{4}$ ij	
	Tinct. opii, . . . . .	$\frac{3}{4}$ ss	
	Aquaæ bul., . . . . .	Oij.	M.

Dr. Bartholow finds the application of *blisters* an effective method. He says, "I have small blisters, the size of a silver dollar, placed around the joint, leaving an interval between for succeeding applications. It is by no means so painful and disagreeable as it appears at first sight. The blisters remarkably relieve the pain, bring about a more alkaline condition of the blood, and render the urine less acid, or bring it to neutral, or even to alkaline."

The complications are to be treated according to their character.

## MUSCULAR RHEUMATISM.

**Synonyms.** According to location, to wit: *cephalodynia*; *lumbago*; *torticollis*; *pleurodynia*.

**Definition.** An affection of the voluntary muscles, inflammatory in character, either *acute* or *chronic*; characterized by pain, tenderness, and stiffness of the affected muscles. It is never complicated with cardiac disease.

**Cause.** A disease of adult life. One attack predisposes to another. Almost always due to cold and damp, or direct draught of cold air. Gout increases the tendency to attacks.

**Pathological Anatomy.** The true nature of muscular rheumatism is not yet determined. Virchow suggests a "hyperæmia of, and scanty serous exudation between, the muscular striæ, and in chronic cases inflammatory proliferation of the connective tissue."

**Symptoms.** The first attack is generally *acute*. Onset rather sudden, with *pain* in the affected muscles, with slight *tenderness*, and considerable *stiffness*, and *difficulty of movement*, by which also the pain is increased.

The suffering may be severe and constant, or only on motion. *Spasm* of the affected muscles may occur. *Objective symptoms* are wanting, except it is evident that the patient keeps the affected muscles as quiet as possible. Fever is absent. The pain may prevent sleep.

*Duration, acute form*, about one week. *Chronic* returns frequently, and finally becomes constant and aggravated when the weather is damp.

**Varieties.** It may affect any or all of the voluntary muscles, but its most frequent and important varieties are:—

1. *Cephalodynia*. Situated in the occipito-frontal muscle. Distinguished from *neuralgia* of the trifacial, or occipital nerve, by pain on both sides of the head, excited or aggravated by movements of the muscle, and by absence of disseminated points of tenderness.

The muscles of the eye may be affected, and movements of that organ excite pain. If the temporal and masseter muscles are attacked, mastication excites pain.

2. *Torticollis*. Wry neck, or stiff neck. Situated in the sternomastoid muscles. Generally limited to one side of the neck, toward which side the head is twisted, great pain being excited on attempting to turn to the opposite side. Rheumatism of the muscles of the back of the neck, *cervicodynia*, may be mistaken for occipital neuralgia.

3. *Pleurodynia*. Situated in the thoracic muscles, and may be mistaken for pleuritis, or intercostal neuralgia, from which it is differentiated by the absence of the diagnostic features of each. Pain is excited by forced breathing, coughing and sneezing.

4. *Lumbodynia* or *lumbago*. Situated in the mass of muscles and fasciae which occupy the lumbar region. Most common variety. Usually affects both sides. It may set in rapidly and become very severe. Motion of any kind aggravates the pain, often becoming very sharp or stabbing in character. It is sometimes complicated with *acute sciatica*, when the suffering is agonizing.

**Diagnosis.** The different varieties may be mistaken for any of the following ailments, to wit: trifacial, occipital or intercostal neu-

ralgia, pains of progressive muscular atrophy, syphilis, metallic poisons, or painful affections of the loins, arising from calculi or gravel in the kidney.

A careful examination of the history is usually sufficient to arrive at a correct diagnosis.

**Prognosis.** Difficult to eradicate, and in chronic cases to ameliorate; but is not dangerous to life. Death never results.

**Treatment.** *Rest* is the first indication. This is accomplished in *pleurodynia* by firmly strapping the affected side with broad strips of plaster, extending from mid-spine to mid-sternum.

The local application to the affected muscles of *hot poultices*, made of two-thirds *pilocarpus* leaves, and one-third *flaxseed* meal, changing them every two hours, is, in the opinion of the author, the most rapidly successful treatment in acute cases.

Internally, *sodii salicylat.*, gr. xv-xx, every two or three hours, is a most valuable remedy. Prof. Bartholow declares that *lithii bromidum* is almost a specific in muscular rheumatism.

For the *pain*, and consequent sleeplessness, use—

R. Pulv. ipecac et opii, . . . . . gr. x  
Potass. nitras, . . . . . gr. v-x. M.  
SIG.—In powder, morning and night.

Or, hypodermically, at the seat of pain, *morphina*, gr.  $\frac{1}{8}$ - $\frac{1}{4}$ , and *atropina*, gr.  $\frac{1}{80}$ , p. r. n.

The following liniment is valuable in many cases:—

R. Quininæ sulph., . . . . . gr. xl  
Ol. gaultheriae, . . . . . f  $\frac{2}{3}$  j.  
Lin. saponis co., . . . . . f  $\frac{2}{3}$  iiij. M.  
SIG.—Thoroughly applied several times a day.

In attacks where the disease is limited to a few muscles, the following liniment is valuable:—

R. Chloral hydrat.,  
Camphoræ, . . . . . ää . . . . . 3 ss  
M. et adde  
Lanoline, . . . . . . . . . . . 3 j. M.  
SIG.—Apply locally.

*Chronic cases:* Rest, flannel worn next to the skin, stimulating and anodyne liniment, mild galvanism, dry heat, as ironing over the

affected part with a common flat-iron, a piece of paper, or towel, being placed next to the skin.

Internally, *potassii iodidum*, *ammonii murias*, *sulphur*, *guaiacum* or *arsenicum* variously combined.

## RHEUMATOID ARTHRITIS.

**Synonyms.** Arthritis deformans; rheumatic gout.

**Definition.** An inflammation of the joints, accompanied with but slight fever, without suppuration, progressive in character, causing nearly symmetrical enlargement and deformity of various articulations.

**Causes.** More common in females than in males, and in the weak and anaemic. Among the causes are bad hygiene, exposure, prolonged lactation, frequent pregnancies, menopause, grief, tubercular diathesis, and following attacks of articular rheumatism.

**Pathological Anatomy.** It is not rheumatism, as the blood contains no *lactic acid*. It is not gout, as *uric acid* is not found in the blood nor *urate of sodium* in the joints.

At first rheumatoid arthritis is attended with hyperæmia of the affected synovial membrane and increase of the synovial fluid. Soon the capsular ligament becomes irregularly thickened, the synovial fluid decreasing. If the process continue, the internal ligament is destroyed, thus allowing dislocations to occur. The inter-articular fibro-cartilages ulcerate and disappear, as do the cartilages covering the ends of the bones, the ends of the bones becoming smooth and eburnated, and often greatly enlarged.

**Symptoms.** Either *acute* or *chronic*, the latter most common.

*Acute* form involves several joints at the same time, and is attended with slight pyrexia.

*Chronic* form slowly involves one joint, which seemingly soon recovers, and is attacked again, and may never recover, but grows progressively worse.

The joint slowly enlarges, is *painful*, movement exciting *neuralgic pains* along the limb. Soon the articulation becomes *rigid* or slightly movable after prolonged attempts. Redness and tenderness are wanting. *Crepitation* is distinct after ulceration has destroyed the cartilage.

The hands are first involved, the disease spreading symmetrically from articulation to articulation, until in severe cases every joint is deformed.

**Diagnosis.** *Chronic articular rheumatism* is often confounded with rheumatoid arthritis; but the former lacks the marked structural changes and the progressive involvement of joint after joint.

*Gout* differs from rheumatoid arthritis by the presence of deposits of urate of sodium in the joints, the ears, tips of fingers and the bursæ over the olecranon process of the elbow, the presence of uric acid in the blood, and the decided history of acute paroxysms.

*Gonorrhœal rheumatism*, so-called, has symptoms akin to rheumatoid arthritis, but the history of urethral suppuration clears up the diagnosis.

*Paralysis agitans*, when pronounced, might be confounded with rheumatoid arthritis, if the examination were limited to the joints, but the whole history, such as the tremor, the gait, etc., should prevent error.

**Prognosis.** If early treatment be instituted, the disease may be held in abeyance for several years. After pronounced structural changes have begun, the malady is incurable, although it may remain stationary for a long time.

**Treatment.** If treatment be instituted before serious structural lesions have occurred, the author has seen benefit in many cases by the following treatment: *Oleum morrhuae* carefully and thoroughly rubbed into the affected joints, three times a day, with the internal use of *lithii citras effervescentes* 3*j*, three times a day, and the following *tonic* mixture:—

R.	Massæ ferri carbonat., . . . . .	gr. v
	Liquor. potass. arsenit., . . . . .	m. v
	Vini xericī, . . . . .	3 <i>j</i>
	Aque, . . . . .	3 <i>j</i>

After meals, well diluted.

*Sodii salicylicum* is recommended early in the disease.

Complete recoveries are reported from the long-continued administration in small doses of *liquor potassii arsenitis*.

Attention to diet and hygiene are also necessary. When structural changes have destroyed portions of the joint, palliative treatment is the only indication.

## GOUT.

**Synonyms.** Podagra, gout in the foot; chiragra, the hand; gonagra, the knee.

**Definition.** A constitutional disease, usually inherited; characterized by the sudden occurrence of a paroxysm of severe pain and swelling in one of the smaller joints—the great toe usually—with the presence of uric acid in the blood, and the deposit of the urate of sodium in the structure of the joint.

**Causes.** *Predisposing;* inherited; male more than female—women after menopause.

*Exciting.* Malt liquor and wine drinking, whether male or female; large consumption of animal food; lead poisoning; winter season.

When inherited tendency, may begin early in life; when acquired tendency, after thirty-five years.

*The pathological cause* consists in the presence of an excess of *uric acid* in the blood, in the form of *urate of sodium*.

**Pathological Anatomy.** Gout is characterized by the deposit of *urate of sodium* from the blood into the structure of joints and tissues that are not very vascular. The deposit is associated with signs of inflammation, to wit: hyperæmia, redness of the surface, with swelling and effusion in and around the affected joint. The surfaces of the joint are incrusted with chalk-like masses, consisting of urates, which become greater with each attack, finally causing great deformity.

The deposit usually begins in the metatarso-phalangeal joint of the great toe, but other and many joints are soon affected.

The deposits may also be found in the knuckles, eyelids, and cartilages of the ear.

"Crystals of urate of soda are deposited in the tubules and intra-tubular tissues" of the kidneys—"gouty kidney"—and may be seen by the naked eye, the kidneys becoming small, granular and fibrous.

Hypertrophy of the left ventricle and of the arteries, ending in atheromatous changes, are results of gout.

**Symptoms.** *Acute gout* is rare in the United States. It occurs in paroxysms; one year's interval between the first and second attack; six months usually between the second and third, after which it may occur at any time.

*Prodromes* usually precede the paroxysm for several days, to wit: acid dyspepsia, constipation, headache and lassitude.

The *paroxysm* begins suddenly, between midnight and 2 A. M., with acute *pain* in the ball of the great toe, which becomes *red, hot, swollen*, and *so sensitive* that the slightest touch cannot be borne.

The veins are filled, the foot, ankle and leg swollen, and the limb the seat of sudden spasmodic contractions, which increase the suffering; slight relief is afforded by elevating the limb. Associated with the local symptoms are, *chill, fever, quickened pulse, thirst, coated tongue, constipation, and scanty, acid, high-colored urine*, which deposits, on cooling, a heavy *brick-dust* sediment.

Towards daylight the symptoms ameliorate, to return again at sundown, the severity gradually lessening, until the fourth or fifth day, when convalescence is established, the patient, as a rule, feeling better than before the attack.

*Chronic Gout.* Either the result of acute attacks or with a greater number of joints being attacked.

The *paroxysms* occur at any time, but develop slowly, with less pronounced local and general symptoms. Deposits are noticed, the joints becoming hard, knobby, and often distorted. The deposits or *chalk-stones* (urate of sodium) occur about the joints, tendons and bursæ, and helix of the ear.

**Diagnosis.** An error cannot occur if the history of the case can be obtained, to wit: hereditary tendency, age, sex (females rare, until menopause), mode of living, character of symptoms and presence of the characteristic deposits.

**Prognosis.** Acute gout rarely fatal; is prone to return, but much depending upon the mode of living.

Chronic gout decidedly shortens life. The most serious signs are those indicating advanced renal disease, with non-elimination of uric acid. Gout influences unfavorably the prognosis from acute diseases or injuries.

**Treatment.** For the *acute paroxysms* at once, *vinum colchici radicis*, gtt. xv-xx-xxx, every two hours, *well diluted*, either alone or in combination with a *potassa* salt, or *sodii salicylas*, gr. xx, every three or four hours, well diluted, or Prof. Bartholow's pill,

R. Colchicinae, . . . . .	gr. $\frac{1}{6}$
Ext. colocynth. comp., . . . . .	gr. ss
Quininæ sulph., . . . . .	gr. iiij.

Every two or three hours.

Or the following, recommended by Loomis :—

R.	Pulv. ipecac., . . . . .	gr. j	
	Ext. colchici acet., . . . . .	gr. j	
	Hydrargyri chlor. mite, . . . . .	gr. j	
	Ext. aloes aq., . . . . .	gr. j	
	Ext. nucis vomicæ, . . . . .	gr. $\frac{1}{4}$ .	M.

Ft. pil. No. I.

SIG.—Every three hours.

For the *pain*, hypodermic injection of *morphina*, and wrapping the inflamed joint in cotton wool saturated with *liq. plumb. sub-acetat. dil.* and *tinctura opii*.

The diet must be restricted to liquid food.

For *chronic gout*, regulated diet, free action on the secretions, and *lithii citras effervescentes*, 3j, three or four times a day, well diluted with water; and perhaps a course of *quinina*, *ferrum* and *arsenicum*.

To prevent paroxysm, keep secretions acting, by the free use of pure water or a good alkaline water, especially the Saratoga Vichy.

The diet is of the greatest importance, and should consist chiefly of vegetables and fruit, excepting tomatoes and strawberries; fresh meat may be used once a day, as may oysters, fish and soups. Alcoholic and malt liquors are contraindicated, as are tea and coffee; skimmed milk should replace all the above. No eggs or dishes containing eggs, no pastry, hot bread or cakes, no sweetmeats, spices or condiments.

Systematic exercise, especially walking, is of great advantage.

Cold bathing, with caution, while the vapor or Turkish bath are of benefit.

Changing from a cold to a warm climate in winter, and the use of flannel under-clothing, are strongly recommended.

## LITHÆMIA.

**Synonyms.** Lithiasis; uric acid diathesis; half gout.

**Definition.** A condition in which the fluids of the body are saturated with nitrogenized waste, in the form of *lithic* or *uric acid*; characterized by marked dyspepsia, various nervous phenomena, muscular and articular pains, bronchial catarrh, all or any of these associated with scanty, high-colored, acid urine.

**Causes.** High living, with little exercise; imperfect digestion of nitrogenized food; impaired elimination of uric acid.

**Symptoms.** Those of *dyspepsia* associated with *irregular bowels*, scanty, high-colored, *acid urine*, sp. gr. 1.024-1.028, containing neither sugar nor albumin, but showing an increased proportion of *urates*. Also, *depressed spirits, impaired memory, loss of interest in occupation, sleepless nights, attacks of vertigo, neuralgic pains in the head, and a constant dread of apoplexy or cerebral disease*. Also, *pains in the joints, neuralgic in character*.

If the condition be allowed to continue, the following organic changes may result, to wit: fatty heart; fibroid kidney; enlarged liver, or changes in the cerebral vessels.

**Diagnosis.** From gout, by the absence of acute paroxysms and resulting changes in the joints,

**Prognosis.** If properly recognized and treated, complete recovery will result, although it is a disorder of long duration.

If not properly treated, develops some one of the organic diseases mentioned.

**Treatment.** Regulate diet, using fresh meat once daily, poultry, game (plainly cooked), fresh fish, oysters, occasionally eggs, lettuce, spinach, celery, cold slaw and tomatoes; avoid all stimulants, tea and coffee, using milk, skimmed milk or milk and cream. Act freely on all the secretions. Systematic exercise. Avoid tonics, bromides, chloral and opium. Long course of alkaline waters. Good results follow *lithii citras*, gr. xx, t. d., *sodii phosph.*, gr. xxx, ter die, or *acidum benzoicum*, gr. x, t. d., all well diluted with water. The author strongly urges the use of *acidum nitricum dilutum*, gtt. x, in half a glass of water, four times a day, with the occasional use of *pilulae rhei compositæ* at bedtime.

## DIABETES MELLITUS.

**Synonyms.** Glycosuria; melituria.

**Definition.** A chronic affection characterized by the constant presence of grape sugar in the urine, an excessive urinary discharge, and the progressive loss of flesh and strength.

**Causes.** Most common in males. Occurs at all ages, but most frequently between twenty-five and fifty years. It is often hereditary.

Disorders of the nervous, hepatic and renal systems. Excessive use of farinaceous food and malt liquors. Sexual excesses.

The exact *pathology* of diabetes mellitus differs in different cases, and in the present state of our knowledge no exclusive view can be adopted. Still, there are reasons for believing that, in a large proportion of cases, the nervous system is primarily at fault, though the character of the lesions may differ.

**Pathological Anatomy.** None peculiar to diabetes are yet recognized.

Hyperæmia and hypertrophy of the liver and kidneys are generally present, the result of increased functional activity.

The changes in the lungs peculiar to phthisis are often found in very chronic cases.

The changes in the nervous system are not fully determined.

**Symptoms.** Clinically cases differ greatly in their course and severity; one class presenting slight symptoms and a chronic course; another class having marked local and constitutional symptoms and an acute course. The symptoms of a typical case may be arranged under the following heads:—

*Urinary Organs and Urine.* Micturition more frequent and the urine increased in quantity. Pain over the region of the kidneys. The quantity of urine may amount to 4, 8, 12, 20 or 30 pints in twenty-four hours. It is usually pale, clear and watery, having a sweetish taste and odor, the specific gravity ranging from 1.025 to 1.050. It ferments rapidly if kept in a warm place. It yields grape sugar to the usual tests, the amount present varying from an ounce to two pounds in the twenty-four hours.

The urea and uric acid are increased. Albumen may be present.

The increased passage of a large quantity of saccharine urine causes a constant itching, burning and uneasy sensation at the prepuce, along the urethra, and at the neck of the bladder; in females, itching and eczema of the vulva are common; in children, incontinence of urine is frequent.

*Digestive Organs.* An almost constant symptom is thirst, with a dry and parched condition of the mouth. At times the appetite is excessive, again absent. The breath may have a sweetish odor, the tongue irritable, red and often cracked. *Dyspeptic symptoms* are common, and occasionally vomiting. The bowels are constipated, the stools pale and dry. At times diarrhœa may occur.

The patient complains of feeling *very weak*, languid, and of *soreness and pain in the limbs*, there is more or less *emaciation*, a harsh, dry skin, the countenance distressed and worn.

The mind is often greatly altered; depression of spirits, decline in firmness of character and moral tone, with irritability, are present. Sexual inclination and power are diminished. Defects of vision are present.

*The blood and various secretions contain sugar.*

**Complications.** Pulmonary phthisis; Bright's disease; defects of vision from atrophy of the retina or the formation of a soft cataract; boils and carbuncles, and chronic skin affections, such as psoriasis and eczema.

**Course.** The clinical history varies in different cases. In the majority of instances the course is chronic, lasting for years, the symptoms beginning insidiously, and becoming progressively worse, with, at times, decided remissions. Occasionally the disease runs an acute course, death occurring within four or five weeks.

**Termination.** The majority of cases ultimately prove fatal, the symptoms markedly changing, the urine and sugar diminishing in quantity, the occurrence of albuminuria, disgust for food and drink, and the development of hectic fever or colliquative diarrhoea.

The fatal result usually arises from gradual exhaustion, from blood poisoning, leading to stupor, ending in complete coma, or occasionally to delirium or convulsions, or from complications.

Rarely, death occurs suddenly, from uræmic convulsions or uræmic coma.

**Diagnosis.** Diabetes mellitus only exists when grape sugar is permanently present in the urine. "It is not the quantity, but the persistence of sugar which constitutes diabetes."

When are present grape sugar in the urine, with more or less increase in the urinary flow, it can be mistaken for no other affection.

From Bright's diseases, by the absence of dropsy, and of tube casts in the urine; the amount of albumin in the urine is never so great or constant in diabetes mellitus as in Bright's diseases.

From Diabetes Insipidus, by the absence of sugar in the blood and urine, and the larger quantity of urine voided in polyuria.

*Simple glycosuria* differs from diabetic glycosuria in that the amount of sugar in the urine is not constant—at one time being present, at another absent—the amount of urine voided is never in excess of

health; simple glycosuria is a disease of the aged; diabetic glycosuria usually appears under fifty years. Simple glycosuria often results from the inhalation of chloroform, the use of chloral, in the insane, from excitement, or the result of injuries to the head.

**Prognosis.** Most unfavorable as regards a cure, it being fairly questionable if complete recovery has ever occurred in a typical case. Still, decided amelioration may take place in the symptoms, and the progress of the malady be greatly retarded. The younger the patient, the more rapid the fatal termination.

**Treatment.** Impress upon patients the importance of a strictly regulated diet. Prohibit or restrict the consumption of such articles as contain sugar or starch, especially ordinary bread or flour, sugar, honey, potatoes, peas, beans, rice, arrowroot, cracked wheat, oat meal, turnips, beets, corn and carrots; prunes, grapes, figs, bananas, pears, apples, and liquors of all kinds whether distilled or fermented.

The main diet should be of *animal food*, including meat, poultry, game and fish.

A moderate amount of fluids should be allowed, and in a majority of cases milk will prove beneficial, although, theoretically, contraindicated. Tea, coffee and cocoa, without sugar, may be allowed in moderation, glycerin or saccharin being used as a substitute for the sugar.

Regulated exercise is of importance. The patient should wear flannel, and have two or three warm baths every week, or an occasional Turkish bath.

**Therapeutical Treatment.** It is difficult to estimate justly the action of any drug in this disease, for, as is so well known, a proper modification of the diet will alone produce the most marked improvement.

Opium exercises an influence over the excretion of sugar, but the effect is not maintained in all cases. Pavy strongly urges the use of codeia in doses of gr.  $\frac{1}{2}$ -iiij, three times a day. The use of morphina hydrochloras, gr. j daily, or pulvis opii, gr. iij-v daily, or codeina, gr. v-x-xv daily, I have seen of some value. Prof. DaCosta suggests the use of ergota, which has decreased the urinary discharge and the quantity of sugar in a number of cases. Prof. Bartholow has met with an apparent cure by ammonii carbonas. The author has met with decided partial success with uranii nitras, gr. j-iiij, three times a day, the cases not yet being under observation a sufficient length of time to pronounce them cured, although in two the urine has been

diminished from three quarts per day to normal, the quantity of sugar from nine ounces to less than half an ounce, in the twenty-four hours. *Liquor bromidum arsenitis*, ℥ iij-v three times a day often gives good results. Dickinson remarks that "strychnina is, of all remedies, the most constantly useful."

*Potassii bromidum*, ʒj during the twenty-four hours is strongly urged. The following remedies are recommended by different observers, to wit: *pepsinum*, *liquor potassii arsenitis*, *iodum*, *potassii iodidum*, *sodium salicylas*, *acidum lacticum*, *glycerinum*, *quinina* and *tinctura cannabis indica*. The evidence in favor of the majority of these drugs is far from satisfactory.

Symptomatic treatment is mostly called for. For emaciation and anaemia, *ferrum* and *oleum morrhuae*; for sleeplessness and restlessness, *morphina*, *potassii bromidum*, *chloral*, or *hyoscyamia*. For boils and carbuncles *calcii sulphide*. Duchenne suggests the following solution for the excessive thirst of diabetic patients:—

R. *Potassii phosphat*, . . . . two parts  
*Aqua*, . . . . . seventy-five parts.

SIG.—One teaspoonful twice or thrice daily, in wine or hop tea.

The dyspepsia and lung symptoms must be managed on general principles.

The constant galvanic current has been productive of good results. A change of scene and air is beneficial.

Surgical operation should on no account be undertaken on diabetic patients.

### DIABETES INSIPIDUS.

**Synonyms.** Polyuria; polydipsia.

**Definition.** An affection characterized by the habitual discharge of a very large quantity of pale, watery urine, free from albumin and sugar.

**Causes.** Occasionally hereditary, or diabetes mellitus may have existed in the parent; more common in children or young adults; men are more liable than women; injuries and diseases of the nervous system; exposure to cold; drinking freely of cold water; fatigue; prolonged debility; malaria; syphilis.

The probable immediate cause of the excessive flow of urine consists in dilatation of the renal vessels, the result of paralysis of their

muscular coat, caused by derangement of innervation, as the condition can be induced experimentally by irritating a spot in the fourth ventricle, or by section of portions of the sympathetic nerve.

**Symptoms.**—The affection is characterized by *great thirst*, with an increased flow of pale, watery, slightly acid urine, the amount varying from *one to five or six gallons* in the twenty-four hours. The *specific gravity* ranges from *1.001-1.007*. *Sugar and albumin are absent*. Urea and the other solids are increased. The *appetite* is voracious, the *bowels* are obstinately constipated, and the *skin* is dry and harsh.

The large flow of urine is usually preceded by various nervous phenomena as *nervousness, irritability, inability to concentrate the mind, vivid imagination, failure of memory, and headache*.

Unless the affection is soon arrested great loss of flesh and strength result.

**Diagnosis.** It differs from *diabetes mellitus* by the absence of grape sugar in the urine.

From *paroxysmal diuresis*, by the absence of the increased urine permanently.

From *interstitial nephritis*, by the greater amount of urinary discharge and the absence of albumin, œdema, etc.

**Prognosis.** Rather unfavorable as to a radical cure, unless caused by syphilis. Death rarely is due to the diabetes, but to some intercurrent malady that the patient has been unable to withstand, on account of the weakness produced by the diabetes.

**Treatment.** If due to syphilis, *potassii iodidum* and *hydrargyrum* are of real benefit. Prof. Da Costa has had success with *ergota* in the form of the fluid extract or the aqueous extract. *Pilocarpus* has been used with success. Prof. Bartholow recommends *galvanism* in cases not cured by *potassii iodidum*, placing "one electrode to the neck below the occiput, the other to the hypochondriac regions in turn." *Valerian* and *potassii bromidum* have been used. The author has effected a cure in three cases, where other remedies had failed, by the use, internally, of—

R. Strychninæ sulph., . . . . .	gr. $\frac{1}{40}$
Acid. hydrochlor. dil., . . . . .	m <sup>x</sup>
Aquæ lauro-cerasi, . . . . .	3 ij.
Well diluted.	M.

The obstinate constipation is best overcome by *pilulæ catharticæ compositæ*, one at bedtime.

## CHOLERA.

**Synonyms.** Epidemic cholera; Asiatic cholera; malignant cholera; spasmodic cholera.

**Definition.** An acute, specific, infectious disease, epidemic in the majority of, although endemic in other, localities; characterized by the transudation of serum into the stomach and intestinal canal and violent purging of a peculiar, rice-water-like fluid, the persistent vomiting of a similar material, severe muscular cramps, and a condition of prostration, followed by collapse and death, or of a reaction from the collapse and the development of the typhoid state (*cholera typhoid*).

**Causes.** A *specific poison*, probably the "comma bacillus" of Koch. Cholera is but feebly *contagious*, in the usual acceptation of that word, but it is unquestionably *infectious*.

The evidence seems conclusive that the *cholera stools* are the main, if not the only, channel of infection, and that the great cause of the propagation of cholera is the contamination with the stools of the water used for drinking purposes. Milk may also be the vehicle by which it spreads. Little, if any, danger exists from being in the presence of the affected, although the emanations from the cholera excreta in the atmosphere may generate the disease if swallowed or inhaled. The dead bodies of cholera subjects apparently possess slight infective property, "the bacteria of decomposition" probably destroying the cholera germs. One attack does not afford protection against another.

The *period of incubation* is short, under a week, usually.

**Pathological Anatomy.** This is, as yet, far from satisfactory. The morbid appearances in the majority of cases of death from cholera may be thus summarized: The temperature generally rises after death, the body remaining warm for a considerable time. Rigor mortis rapidly ensues, the muscular contractions being often so powerful as to displace and distort the limbs. The skin is mottled and the body greatly shrunken. The blood is darker in color, thick, viscid, feebly coagulable, and slightly acid. The arteries are quite empty of blood, the veins, on the other hand, are distended. The organs are, as a rule, pale and shrunken.

The stomach and intestinal mucous membranes are congested, and present evidence of extravasations and ecchymoses, or are bleached

and pale. The stomach and intestines usually contain a quantity of whey-like material, having an alkaline reaction, as well as quantities of cast-off epithelium and the peculiar bacillus. It is thought by many that the stripping-off of the epithelium is a post-mortem phenomena. The Peyer's, solitary and Brunner's glands are usually enlarged and prominent, and occasionally evidences of ulceration are apparent in the solitary glands, and sections placed under the microscope show the "comma bacillus." The villi of the mucous membrane, as well as the epithelium of the small intestines, are stripped off, leaving the basement membrane, for the most part, exposed. The *liver* is more or less advanced in fatty degeneration, presenting a somewhat mottled, yellowish discoloration. The *kidneys* are congested, the epithelium of the tubules granular and detached from the basement membrane, blocking up the tubes. Prof. Bartholow observed, in all of his autopsies, "considerable hyperæmia and dilatation of the vessels of the medulla oblongata. The constancy of this lesion would seem to indicate a relationship between congestion of the medulla and the cramps."

**Symptoms.** In accordance with the law of epidemic infectious diseases, the onset, course and character of the symptoms vary in different cases and at different periods in the same epidemic.

The disease may either set in suddenly in a patient previously in good health, or it may follow an attack of rather severe and persistent diarrhoea, with *pain, nausea, vomiting and depression*. Such cases are termed *Cholcerine*, the stools of which are infectious.

In a typical case there are three stages: *first*, diarrhoea; *second*, prostration; *third*, collapse, or, in favorable cases, reaction.

*First Stage.* Begins with *chilliness*, excessive *thirst*, coated tongue, unpleasant taste in the mouth, slight abdominal *pain*, and three or four copious, *watery*, yet fecal *stools* during the day, and a decided feeling of *weakness*, the stools rapidly becoming *whey-like*, easily voided, but with force, and only slight pain.

*Second Stage.* The *stools* rapidly increase in number, are voided with a rushing force, and consist of many quarts of grayish, or whitish, *rice-water-like* fluid, accompanied with forcible *vomiting*, first of the contents of the stomach, mixed with more or less bilious matter, afterward of the peculiar rice-water-like material; *thirst* becomes most intense, increasing or diminishing with the variations in the

number of the vomiting and stools; severe muscular cramps soon follow, most severe in the calves, although occurring in all parts of the body.

*Third Stage.* The stools, vomiting and cramps continue. The appearance of the patient becomes frightful; the eyes are sunken and surrounded by blackened rings, the nose pinched and pointed, the cheeks hollow, and the lips blue (*facies cholérica*); the surface cold and moistened with a sticky perspiration; the skin of the hands and fingers have the sodden appearance of the "washerwoman who has washed all day," and if picked up in folds, the fold but slowly disappears. The temperature rapidly falls, the pulse becomes small and compressible, barely perceptible at the wrist, and the heart beats are scarcely recognizable. The voice is weak, husky and sepulchral (*vox cholérica*), the tongue is like ice, the breath is cold and icy, the urine markedly diminished and albuminous. The mind is not cloudy, but most patients are apathetic and indifferent to their danger. This, the *algid* stage of cholera, or *cholera asphyxia*, usually terminates in death in from three to twelve, twenty-four or forty-eight hours, but reaction may be established.

*Stage of Reaction.* The temperature of the body rises, the pulse gradually becomes fuller and stronger, the countenance becomes brighter, the stools less frequent and more fecal, the vomiting decreases, the thirst lessens, the urine increases in amount, but continues albuminous, the patient entering a slow convalescence, or *typhoid symptoms* develop, the so-called *cholera typhoid*, which prolongs the recovery for several weeks.

Convalescence is often prolonged and complicated by the development of severe bed sores, boils, bronchitis, pneumonia or parotitis.

*Sequelæ.* Suppuration of the parotid gland; painful tetanic contraction of the flexor muscles of the limbs; abscesses or ulcers of the limbs; profuse sweats; roseola, erythema, urticaria, and rarely vesicular eruptions.

*Diagnosis.* The epidemic character, and rapid spreading, and great mortality of the affection prevents its being mistaken for any other disease, although isolated cases are often confounded with cholericine or with cholera morbus, the points of distinction being few, unless the "comma bacillus" only be found in the stools of true cholera.

**Prognosis.** Very unfavorable, the mortality ranging from twenty to eighty per cent. The last epidemic in this country was much milder than former ones. The prognosis is controlled by the general condition of the patient, the age, habits and the development of the algid stage; the prognosis being more favorable in those cases which develop gradually than in those in which it reaches its acme at a single bound; the very young or very old, those addicted to the various excesses and surrounded by unfavorable hygienic conditions, are more apt to perish than are others.

**Treatment.** The success depends, to a great extent, upon its prompt and early treatment, for experience amply attests that the arrest of the disease in the diarrhoeal stage is comparatively easy, and that in the stage of collapse its cure by any means whatever is altogether an exceptional occurrence; therefore, during the prevalence of cholera the mildest cases of diarrhoea ought to receive prompt treatment, for many cases have their beginning as a mild diarrhoea.

It must not be overlooked that intelligent nursing and regimen are equally as important as medical treatment.

*First Stage.* The remedy of all others is *opium* in some form, to which may be added, with benefit, *plumbi acetum*, in doses of gr. iij-v, repeated p. r. n., or *acidum sulphuricum dilutum* combined with *tinctura opii deodorata*, and at the same time applying *mustard* over the abdomen. Water and food should be used with great caution, but *ice* is indicated in unlimited amounts, and at times *iced dry champagne*. The patient must be kept quiet, in bed.

Ziemssen says: "Calomel has the first place of all drugs which have been recommended in the prodromal stage. Begin with two or three doses of gr. vij, followed with small doses—gr.  $\frac{3}{4}$ —every two hours."

*Second Stage.* The *opium* treatment should be continued, together with the free use of *stimulants*. For the distressing vomiting, *ice*, *iced champagne*, *acidum carbolicum* or *acidum hydrocyanicum* may sometimes give relief.

*Locally* either continue the *mustard* application to the abdomen or the constant use of rubber bags filled with boiling water, or cold cloths.

For the *cramps*, hot water in bottles, hot irons or bricks applied over painful parts, or an ointment of chloroform or chloral, chloroform or ether inhalations, or the use of the following hypodermic solution, strongly recommended by Prof. Bartholow:—

R. Chloral, . . . . . 3*ijj*  
 Morphinæ sulph., . . . . . gr. iv  
 Aq. lauro-cerasi, . . . . . f*3j*. M.  
 SIG.—Fifteen to thirty minims each injection.

For the collapse, heat to the surface and the free use of *stimulants*, or *spiritus frumenti*, or *spiritus vini gallici*, hypodermically, also the hot, and, in some cases, the cold bath has been of advantage; the intravenous injection of saline fluids was unusually successful during the 1884 epidemic in France, and as the *modus operandi* becomes more perfect, its success will be the more marked.

If reaction occur, treat indications as they arise, and use tonics, such as *ferrum*, *quinina* and *arsenicum*.

All the discharges from the patient should be thoroughly *disinfected* as soon as voided, and the stools and vomited material buried.

### TRICHINOSIS.

**Synonyms.** Trichinæ; *Trichina spiralis*; "flesh-worm disease."

**Definition.** A typhoid condition, the result of the entrance of a parasite—the *Trichina spiralis*—into the intestinal canal, and their subsequent migration into the muscular structure: characterized by severe gastro-intestinal irritation, severe muscular soreness, and a low typhoid condition.

**Cause.** The *Trichina spiralis* are introduced into the human body by eating the infected hog's flesh, either raw or but imperfectly cooked.

**Description.** The parasite is found in two forms, to wit: *intestinal trichina*, which is sexually mature, and *muscle trichina*, which is sexually immature.

The *intestinal trichina* is a small, hair-like worm, the male measuring  $\frac{1}{18}$  of an inch, and the female  $\frac{1}{8}$  of an inch in length; the head is smaller than the rest of the body; the tail of the male has a bi-lobed prominence, between the divisions of which the anal opening is placed, and from which a single spiculum can be protruded; the female has a blunt, rounded tail, the reproductive outlet being situated toward the anterior part of the body; the ova are very small, containing embryos being produced viviparously at the rate of at least one hundred each week after the entrance of the female into the intestinal canal.

The *muscle trichina* develops its sexual apparatus after it has entered the intestinal canal of the host.

The viable embryos discharged from the female are in a state of motion, and at once migrate from the intestines to the muscular structure of the individual, and here set up inflammatory action, they becoming surrounded by a capsule or shell in which they are coiled.

After a time, in the muscle, the *trichina* undergoes a further change; lime salts being deposited in and about the capsule and in the parasite itself, when minute specks of lime are seen distributed throughout the muscular structure.

The development of the parasite from the period of impregnation up to the time of sexual maturity is, under favorable conditions, less than three weeks. Within two days from the ingestion of the infected pork occurs the maturation of the muscle larvæ; in six days more the birth of embryos occur, and in about two weeks the migrating progeny have arrived at their *habitat*, the muscular structure.

**Symptoms.** These depend upon the number of parasites in the infected food. According to Dr. Sutton, of Indiana, a piece of pork the size of a cubic inch contained eighty thousand trichinæ. There are three stages described, to wit: the *intestinal*, the *migration*, and the *encapsulation*.

*Intestinal stage*, a gastro-intestinal inflammation, with *nausea*, *vomiting*, and a *watery diarrhœa*, the severity depending upon the number of the parasites ingested.

*Migration stage*, a *typhoid-like fever*, *rapid, feeble pulse*, profuse *sweats*, intense *thirst*, dry tongue and lips, and *red, swollen face*, with *soreness and tenderness of the muscular structure*, increased by any muscular act. As a rule the mind is clear but decidedly *apathetic*.

*Encapsulation Stage.* If the number of parasites ingested have been few, recovery may occur in this stage, but if the number have been large, the *gastro-enteritis*, *fever* and *muscular phenomena* are severe, the patient is in a critical condition, between twenty and fifty per cent. succumbing.

**Diagnosis.** Unless the physician has some intimation of the cause, cases are readily mistaken for either ordinary *ileo-colitis* or *typhoid fever*.

**Prognosis.** Depends upon the number of trichina in the pork eaten. Mortality between twenty and fifty per cent.

**Treatment.** The preventive treatment consists in eating no pork

that has not been so prepared as to kill any trichinæ that might exist. If the parasites have been recently taken, within the first four or five days, *emetics* and *purgatives* to remove them from the stomach and intestinal canal are indicated. After thorough action from these, attempts may be made to destroy such of the parasites as have escaped the action of the emetic or purgative. For this purpose much is said in favor of *glycerini*, one part, *aquaæ*, two parts; or a trial can be made of *acidum carbolicum* and *tinct. iodi*, as suggested by Prof. Bartholow. *Quinina* gave the best results in the cases seen by Dr. Sutton.

After *migration* has begun the powers of life should be sustained by nourishing food, stimulants and tonics.

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## DISEASES OF THE RESPIRATORY SYSTEM.

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### PHYSICAL DIAGNOSIS.

**Physical Diagnosis** is the art of discriminating disease by means of the eye, the ear and the touch.

The *signs* thus ascertained are connected with changes or alterations in the form, density, or condition of the structures within, and are known as *physical signs*.

"*Physical signs are, then, the exponents of physical conditions, and of nothing more.*"

The methods employed in the physical exploration of the chest, are:—I, **Inspection**; II, **Palpation**; III, **Mensuration**; IV, **Percussion**; V, **Auscultation**; VI, **Succussion**.

*Percussion* and *auscultation*, dealing with sounds, are of the greatest value clinically.

For the purposes of physical exploration, the chest is mapped off into regions or divisions, as follows:—

#### ANTERIORLY.

First:—*Supra-clavicular*, Lying above the upper edge of the clavicle, usually about an inch in extent.

Second :—*Clavicular*, Corresponding to the inner two-thirds of the clavicle.

Third :—*Infra-clavicular*, From the clavicle to the lower border of the third rib.

Fourth :—*Mammary*, Between the third and sixth ribs.

Fifth :—*Infra-mammary*, Downward from the sixth rib.

#### LATERALLY.

First :—*Axillary*, That portion above the sixth rib.

Second :—*Infra-axillary*, That portion below the sixth rib.

#### POSTERIORLY.

First :—*Supra-scapular*, That portion above the scapula.

Second :—*Scapular*, That portion covered by the scapula.

Third :—*Inter-scapular*, That portion between the scapulæ.

Fourth :—*Infra-scapular*, That portion below the angle of the scapula.

### INSPECTION.

**Inspection** signifies "the act of looking." Views of the chest should be taken from the sides and behind as well as from the front; for which purpose a good light should be obtained, and the patient be placed in as easy and comfortable a position as is possible.

Inspection reveals the *form, size, color, and movements* of the chest, as well as the condition of the superficial parts.

In *health* the sides of the chest are for the most part *symmetrical* in form, size, color and movements, both sides rising equally during the act of inspiration, and falling equally during the act of expiration. During the act of inspiration the intercostal spaces in the lower two-thirds of the chest become more hollow, as also do the supra-clavicular fossæ.

*Inhalation* is almost entirely the result of muscular action; *exhalation*, on the other hand, is chiefly due to the elasticity of the lungs and chest walls, aided somewhat in forced respiration by muscular action. The movement of inhalation by inspection is of longer duration than that of exhalation, and the pause between the acts but momentary.

The *respiratory movement* is visible over the whole thorax, although in males and in children it is most distinct at the lower portion (*inferior costal breathing*), while in the female it is most distinct at the upper portion of the chest (*superior costal breathing*).

## PALPATION.

By **palpation** is meant the application of the palmar surfaces of the hands and fingers to the chest, by which means we appreciate impressions which are capable of being conveyed by the sense of touch.

The objects of palpation are :—

*First* :—To give more accurate information regarding what is revealed by inspection.

*Second* :—To locate spots of soreness, the density and condition of tumors, if any be present, the state of the chest walls, the frequency of the breathing, and the action of the heart.

*Third* :—To determine the existence and character of the various kinds of *fremitus* (vibrations).

By **fremitus** is understood certain tactile impressions or vibrations conveyed to the surface of the chest, which are classed and produced as follows :—

*First* :—*Vocal fremitus*, produced by the act of speaking or crying.

*Second* :—*Tussive fremitus*, produced by the act of coughing ; of value especially when the voice is very weak.

*Third* :—*Bronchial fremitus*, produced by the passage of air through mucus, blood, or pus, in the bronchial tubes, during the act of respiration.

*Fourth* :—*Friction fremitus*, produced by the rubbing together of the roughened surfaces of the pleuræ.

When the normal chest vibrates lightly, it is termed the *normal vocal fremitus*.

The *vocal fremitus* is more distinct upon the right side toward the apex.

If the lung be consolidated (denser), the vibration is greater and more easily distinguished,—*the vocal fremitus is increased*.

In feeble persons, or when any cause interferes with the transmission of the vibrations, the *vocal fremitus is diminished or absent*.

## MENSURATION.

**Mensuration**, or measurement of the chest, is of little practical importance, and hence seldom performed. The only measurement likely to be required is the *circular* or *circumferential*, in different

parts of the chest, which is performed with either an ordinary graduated tape measure or a double tape measure, made by uniting two tapes in such a manner that they start in opposite directions from the same point at the *mid-spinal line*. The tapes drawn around each side until they meet at the *mid-sternal line*, on a line immediately above the nipple, or on the level of the sixth rib near its attachment to the cartilage—the sixth costo-sternal joint—the patient first being directed to effect a complete expiration, the number of inches noted, and then to take a deep inspiration, the increase in inches noted, the difference between the two giving a rough estimate of the capacity of the lungs.

In right-handed persons the right side is usually one-half to three-fourths of an inch larger than the left; if larger than this it is usually the result of some abnormal condition.

In well-developed men the chest measures at the upper part about thirty-three to thirty-five inches during expiration, and is increased fully three inches upon inspiration.

## PERCUSSION.

**Percussion**, or "The act of striking," to ascertain the composition of structures, affords signs and information of great value in diagnosis.

There are two methods employed, *immediate* and *mediate*.

*Immediate*, or direct percussion, is performed by striking the thorax directly with the points of the fingers or the palmar surface of the hand. This method of percussion has been generally abandoned, as it does not enable the physician to distinguish, with sufficient correctness, between the various shades of difference in the pitch or quality of percussion sounds.

*Mediate*, or indirect percussion, may be practiced in three different ways, to wit:—

*First* :—With the finger of one hand interposed between the body percussed and the percussing finger.

*Second* :—With the finger acting as a pleximeter and the percussion hammer.

*Third* :—With the percussion hammer and the pleximeter.

The first of these modes affords the most correct and ready information regarding the *resistance* of the parts percussed. The skillful

use of the fingers is more difficult to acquire than that of the pleximeter and hammer; but if the examiner has acquired sufficient skill in its performance, an absolutely accurate result may be obtained. "He who is skilled in digital percussion will be able to percuss equally well with the hammer, the inverse of which does not always hold good." In addition to being proficient in the technical *modus operandi*, it is necessary to possess a sensitive ear, educated to distinguish between the various shades of the sounds.

When the fingers are employed, it is a matter of choice whether one or more fingers are used as the pleximeter. Usually the last phalanx of the first or second fingers of the left hand are used, the other fingers being raised from the chest, so as not to interfere with the sound vibrations; they should be applied firmly and evenly to the surface, thus preventing the slipping of the soft parts, and also to determine the resistance of the chest walls when the blow is given. The rounded ends of the first and second fingers of the right hand are used as a hammer, striking the pleximeter fingers in such a manner that the nails shall not touch the skin of the underlying fingers. The force employed varies in different regions, but usually, for the chest, should be only of moderate degree. Forceful percussion is of use only when the sound of deep-seated organs is desired.

The stroke should be made perpendicularly to the surface and not slanting, as is too often done. The whole movement should proceed only from the wrist-joint, and ought not to be too rapid or unequal, or of great force, the fingers being rapidly withdrawn, so as not to interfere with the vibrations.

The objects of percussion are to elicit certain sounds, and the amount of resistance or elasticity of the organs percussed.

The main sounds elicited by percussion are the dull, clear and tympanitic. Familiarity with the intensity, character and pitch of each of these sounds is essential.

When percussing the healthy chest, the sound obtained is termed the normal pulmonary resonance. It is of variable intensity, depending upon the force of the stroke employed and the amount of adipose and muscular tissues covering the thorax, and the tension of the chest walls.

There is no exact standard of the normal pulmonary or vesicular resonance, but if the two sides of the chest are compared, the normal standard of each person is obtained.

The character is termed *pulmonary* or *clear*, as characteristic of the healthy chest wall. The pitch is always relatively *low*.

The sounds elicited by percussing a healthy chest are not, however, alike over all its parts.

*Anteriorly*, the portion of lung above the clavicle yields a sound which becomes somewhat *tympanitic* as the trachea is approached.

Over the *clavicle* the sound is *clear* and pulmonary at the centre of the bone, but at the scapular extremity it is duller, and towards the sternum it becomes somewhat *tympanitic*.

At the *infra-clavicular region* the resonance is *clear* and distinct, but little resistance being offered to the percussing finger, and the sound elicited may be taken as the type of the pulmonary resonance. In this region, however, a slight disparity exists between the two sides; on the right side the sound is less clear, shorter and of a higher pitch than on the left side.

In the *mammary region* of the right side the resonance of the lung is not so clear, the sound being modified by the size of the mamma and the upper border of the liver. On the left side the heart deadens the sound from the fourth to the sixth rib, and in a transverse direction, from the sternum to the left nipple. This dull sound in the left mammary region is lessened in extent during full inspiration, and in *emphysema*, when the lung more completely covers the heart.

In the *infra-mammary region* on the right side the percussion note is *dull*, except during the act of complete inspiration, when the liver is displaced downward by the inflated lung. In the left *infra-mammary region* the sound consists of a mixture of the dull sound of the heart and spleen and of the clear sound of the lung, together with the *tympanitic* sound of the stomach.

Over the upper part of the *sternum*—above the third rib—the sound is slightly *tympanitic*. Below the third rib, over the sternum, the sound is dull, due to the presence of the heart and liver.

The position exercises some influence on the results of percussion. More accurate results are obtained when the patient is standing or sitting than when recumbent. While the front of the chest is percussed, the arms should hang loosely by the sides; the hands may be clasped across the top of the head during the percussion of the axillary region; during the examination of the back the head must be bent forward and the arms tightly crossed in front.

On the *posterior* surface of the chest the sound also varies according to the part percussed.

Over the *scapulæ* the sound is *duller* than between these bones or below their inferior angles.

Over the *infra-scapular region* a *clear* sound is obtained as far as the lower border of the tenth rib on the right side, where the dullness of the liver begins. On the left side, below the angle of the scapula, the percussion sound is *tympanitic* if the intestines are distended, or it may be slightly dull if the spleen be enlarged.

In the *axillary* region the sound is *clear* and distinct on each side.

In the *infra-axillary* region of the right side the sound is *duller*, owing to the presence of the liver; at the corresponding situation on the left side, the sound is *clear* or *tympanitic*, from the distention of the stomach, and at the ninth or tenth rib of the left axillary region dullness and the sense of resistance mark the location of the spleen.

The sounds obtained by percussion of the *unhealthy* or abnormal chest are as follows:—

*First* :—*Hyper-resonance* or an increase of the normal pulmonary resonance is due to the relative increase in the proportion of air to the solid tissues of the lung, providing the tension of the chest walls be not altered, occurring in emphysema of the lungs, atrophy of the lungs, or consolidation of the opposite lung.

*Second* :—*Dullness* or an absence of resonance due to the relative increase of solid tissues in proportion to the amount of air, as seen in the different stages of phthisis, in pneumonia, or pleurisy.

The *pitch* is increased or heightened in proportion to the diminution of the amount of the air and the increase of the solids.

If there be entire want of resonance the percussion note is said to be *flat*; if there is a slight decrease in the resonance of the part the note is said to be *impaired*.

The sense of *resistance* is greater, the more marked the consolidation of the lungs and the greater the tension of the chest walls.

*Third* :—*Tympanitic*, or the drum-like percussion note, is a non-vesicular sound having the character elicited by percussing over the normal intestines; wherever heard it indicates the presence of air in conditions similar to that of the intestines, to wit: inclosed in walls which are yielding, but neither tense nor very thick.

When elicited over the chest it may be due to the transmitted

sound of the distended stomach or colon. It is obtained over the chest in pneumothorax, in moderate pleural effusions above the level of the liquid, over the seat of cavities in the pulmonary tissues, and in oedema of the lungs.

The *tympanitic* percussion note differs from the normal pulmonary resonance in being more ringing in character and of a *higher pitch*.

The *amphoric* or metallic sound is in reality a concentrated tympanitic sound of high pitch, and denotes a large cavity with firm, elastic walls.

The *cracked-pot* or *cracked-metal* sound is another variety of the tympanitic sound. The condition most commonly occasioning this sound is a cavity in the lung tissue, communicating with a bronchial tube. It requires for its development a strong, quick blow of the percussing finger, with the patient's mouth open.

#### RESPIRATORY PERCUSSION.

The percussion sound will vary greatly with the respiratory movements. If a full inspiration be taken and percussion performed, then a full expiration taken and percussion performed, and then the chest percussed during the normal respiration, slight changes in the character and pitch of the note are obtained, which otherwise would escape detection. Prof. DaCosta has designated this method, *respiratory percussion*.

#### AUSCULTATORY PERCUSSION.

This method consists in listening with a stethoscope applied to the thorax, to the sounds elicited by percussion. "It is a serviceable means of determining with accuracy the boundaries of various organs, as those of the lungs or heart, or of the liver or spleen, and yields particularly exact results when carried out with the double stethoscope."

#### AUSCULTATION.

**Auscultation**, or listening to the sounds produced within the chest during the act of respiration, coughing, or speaking, furnishes the most reliable means of studying the condition of the lungs, and is, therefore, the most valuable method of discriminating between the various conditions which may affect the organs of respiration.

Auscultation is either *immediate* or *mediate*.

It is *immediate* when the ear is applied directly to the chest, which may be either denuded or thinly covered.

It is *mediate* when the sounds are conducted to the ear by means of a tubular instrument, termed a *stethoscope*.

For ordinary purposes, *immediate*, or direct auscultation is sufficient, but when it is desirable to analyze circumscribed sounds, as in diseases of the heart, or where the patient objects to this method, on the score of delicacy, or the auscultator objects, on account of the uncleanliness of the person examined, the stethoscope is to be preferred. Moreover, there are certain parts of the chest which can only be explored satisfactorily by the aid of a stethoscope, and moreover, this instrument has the additional advantage of *intensifying* the sound.

In auscultation, the following rules, formulated by Prof. DaCosta, should be observed:—

“ 1. Place yourself and your patient in a position which is the least constrained and permits of the most accurate application of the ear or stethoscope to the surface. Above all, avoid stooping, or having the head too low.”

“ 2. Let the chest be bare, or what is better, covered only with a towel or a thin shirt.”

“ 3. If a stethoscope be employed, apply closely to the surface, but abstain from pressing with it. This may be obviated by steadying the instrument, immediately above its expanded extremity, between the thumb and the index finger.”

“ 4. Examine repeatedly the different portions of the chest, and compare them with one another while the patient is breathing quietly. Making him cough, or draw a full breath, is, at times, of service; especially the former, when he does not know how to breathe.”

#### SOUNDS IN HEALTH.

If the ear be applied over the *larynx* or *trachea* of a healthy person, a sound is heard with both the act of inspiration and expiration. Its *intensity* is *variable*, its *pitch high*, and its *quality tubular* (to wit: a current of air passing through a tube—the larynx or trachea). The duration of the sound during inspiration being somewhat longer than during expiration. A *short pause* follows the act of expiration.

This sound is termed the *normal laryngeal respiration*, and is identical in character, duration and pitch with an important morbid sound, termed *bronchial respiration*.

The sound heard by placing the ear over the lung tissue is different; it is produced in the very finest bronchial tubes and air cells by their expansion and contraction, and is termed the *normal vesicular murmur*.

The *inspiratory portion of the sound* is of variable intensity, its *pitch is low*, its *quality soft and breezy*, designated *vesicular*; its *duration* is during the entire act of inspiration.

The *expiratory portion of the sound* is not always perceptible; it is of *feeble intensity, very low pitch*, its *character soft and blowing*, and its *duration* much less than the act of expiration.

It is to be remembered, however, that the vesicular murmur will be found to vary in the different regions on the same side, and in corresponding regions on the two sides of the chest. These variations within the range of health are especially important, and should be memorized.

*Infra-clavicular Region.*—The vesicular murmur in this region on either side is much more distinct than over any other part of the chest.

On the left side the *inspiratory sound* is of greater intensity, of *lower pitch*, and more distinctly vesicular in quality than that heard upon the right side. On the right side the *expiratory sound* is nearly or quite the same in length as the inspiratory sound, and is *higher in pitch* and more *tubular* in quality than the expiratory sound upon the left side.

*Supra-scapular Region.*—Owing to the small number of air vesicles and the large number of bronchial tubes, and their nearness to the surface, the respiratory murmur has an intense, high-pitched, tubular and expiratory quality.

*Scapular Region.*—Compared with the infra-clavicular region, the respiratory murmur heard over the scapulae on either side is more feeble, and the vesicular quality less marked.

*Inter-scapular Region.*—The murmur in this region differs from the normal laryngeal breathing only in intensity and duration.

*Infra-scapular Region.*—The murmur in this region very closely resembles that heard in the left infra-clavicular region.

*Mammary and Infra-mammary Regions.*—The murmur in these regions differs from that heard in the infra-clavicular region, in being of less intensity.

*Axillary and Infra-axillary Regions.*—The respiratory sound in

the axillary regions it as intense as in any portion of the chest. In the infra-axillary regions the intensity is less and the pitch lower.

#### VOICE IN HEALTH.

If the ear be applied over the larynx or trachea of a healthy person, and he be directed to count "twenty-one, twenty-two, twenty-three," in a uniform tone and with moderate force, there is perceived a strong resonance, with a sensation of concussion or shock, and a sense of vibration, thrill or fremitus, the voice seeming to be concentrated and near the ear. Often the articulated words are distinctly transmitted (laryngophony).

The sounds thus heard are termed the *normal laryngeal resonance*.

If the ear or stethoscope be applied over the third rib anteriorly, on either side of the chest of a healthy person, and he be directed to count "twenty-one, twenty-two, twenty-three," in a uniform tone, with moderate force, a confused, distant hum is perceived, of variable intensity, accompanied with more or less vibration, thrill or fremitus, most distinct in adults, but notably weaker in women than in men.

This sound is termed the *normal vocal resonance*.

If the ear or stethoscope be applied over the third rib anteriorly, of a healthy person, and he be directed to *whisper*, in a uniform manner, the words "twenty-one, twenty-two, twenty-three," there is heard a sound corresponding closely in character to the sound of expiration over the same region during the act of forced respiration ; or, in other words, a feeble, low-pitched, blowing sound.

This sound is termed the *normal bronchial whisper*, and is produced by the air in the bronchial tubes during the act of expiration.

#### SOUNDS IN DISEASE.

The vesicular murmur may undergo, in disease, changes in its *intensity*, its *rhythm*, and in its *character*.

The *intensity* of the respiratory murmur may be :—

1. *Exaggerated or increased.*
2. *Diminished or feeble.*
3. *Absent or suppressed.*

**Exaggerated respiration** differs from the normal vesicular respiration only in an increase in the intensity of the respiratory sounds. When general over one lung, it will usually indicate deficient action of other parts. In this manner an effusion compressing one

lung, one-sided deposits, obstruction of the bronchial tubes by secretion, or inflammation of the lung structure, necessitate a *supplementary* respiration in a healthy portion of the same lung or the lung upon the opposite side. From its resemblance to the loud, strong, quick respiration of young children, it has been termed *puerile* respiration.

*Exaggerated respiration* is, therefore, to be regarded as indirect evidence of disease in some portion of the pulmonary tissue.

**Diminished respiration**, called also *senile respiration*, as being characteristic of old age, is characterized by diminished intensity and duration of the sound. In the large majority of instances the inspiration suffers the greatest, the expiratory sound not diminishing in the same proportion. In asthma, emphysema, diseases of the larynx and bronchial tubes, pleuritic pain, rheumatism or paralysis of the chest walls, or in thickening of the pleural membrane, we observe superficial or diminished respiration. When one side of the chest is partially filled with fluid, we may hear a deep-seated, but feeble breath sound.

**Absent or suppressed respiration** occurs whenever the action of the lung is suspended; this may be from external pressure, as when the lung is compressed by the presence of fluid or air in the pleural cavity, or when complete obstruction of the bronchial tubes prevents the air from either entering or escaping from the lungs.

The **rhythm** of the respiratory murmur may be—

1. *Interrupted or jerky.*
2. *The interval between inspiration and expiration prolonged.*
3. *Expiration prolonged.*

In health the inspiratory and expiratory sounds are even and continuous, with a short interval between each act; this may be altered in disease, and both sounds, especially the inspiratory, have an interrupted or jerky character, termed "cog-wheel respiration."

This **jerky breathing** is noted in some spasmoid affections of the air tubes, in hysteria, the earliest stages of pleurisy, pleurodynia, and the early stages of pulmonary phthisis. It is most frequently associated with phthisis, due probably to the adhering to the walls of the finer bronchial tubes of tough mucus, which obstructs the free entrance and exit of the air; it is usually most notable under the clavicles.

The **interval between inspiration and expiration** may

be prolonged, instead of these two sounds closely succeeding one another. When this occurs the inspiratory sound may be shortened, or the expiratory sound may be delayed in its commencement. If the inspiratory sound is shortened, it is the result of consolidation of the lungs; if the expiratory sound is delayed, it is the result of lessened elasticity of the lung structure, and is most commonly associated with emphysema.

**Prolonged expiration** denotes that the air is obstructed in its exit from the lungs. It may be the result of diminished elasticity, the result of emphysema, or from the deposit of tubercles, which impair the contractile power of the lungs. If the former, it is associated with clearness on percussion; if the latter, however, with impaired resonance on percussion. When prolonged expiration is detected at the apex of the lung, and is associated with impairment of the normal pulmonary resonance, it is for the most part the result of a tubercular deposit.

The quality of the respiratory murmur may be

1. *Harsh*, termed *vesiculo-bronchial respiration*.
2. *Bronchial*.
3. *Cavernous*.
4. *Amphoric*.

**Harsh respiration**, or, as it is termed by Prof. DaCosta, *vesiculo-bronchial respiration*, is that variety in which both the inspiratory and expiratory sounds have lost their natural softness. It generally indicates more or less consolidation of lung tissue. In normal vesicular respiration the sounds produced by the air expanding the air cells and finer bronchial tubes obscures the sound produced by the passage of air through the larger bronchial tubes, the healthy lung being an imperfect conductor of sound, so that as soon as any portion of the lung becomes consolidated the vesicular element of the respiratory sound is diminished, the bronchial element becoming prominent. *Harsh respiration* is, then, a union of the vesicular and bronchial sounds, being a vesicular sound mixed with some of the qualities of a bronchial sound, the expiration being prolonged and tubular in character. It is present when the bronchial mucous membrane is swollen, as in the earlier stages of bronchitis, also in the earlier stages of phthisis and pneumonia.

**Bronchial respiration** is characterized by an entire absence of all the vesicular quality. *Inhalation* is of *high pitch* and *tubular* in

character; *expiration* still higher in pitch, of greater intensity, prolonged and tubular in quality; the two sounds being separated by a brief interval.

The bronchial respiration encountered in disease closely resembles that heard in health over the larynx or trachea. Whenever bronchial respiration is present where, in health, the normal vesicular murmur should be heard, it indicates consolidation of the lung structure.

**Cavernous respiration** is a variety of the bronchial respiration, at least so far as the quality of the sound is concerned. It is essentially a blowing sound, yet not always heard during both the act of inspiration and expiration, being often only perceptible in the one, and in the other mixed with gurgling sounds. Its *pitch* is lower than that of ordinary bronchial respiration, and its *character* is hollow.

For its production there must be a cavity of considerable size in the lung substance, not filled with fluid, near the surface of the chest walls, communicating with a bronchial tube. It is met with most commonly in the last stages of pulmonary consumption, although hollow spaces of any kind, from abscess or dilatation of the bronchial tubes, occasion it.

**Amphoric respiration** is a blowing respiration, having a musical or metallic quality. It is a variety of bronchial respiration produced in a large cavity with firm walls, permitting the reflection of the sound. An imitation of this sound, though only an imperfect one, is produced by blowing over the mouth of an empty bottle. The amphoric character is present with both the act of inspiration and expiration.

Amphoric or metallic respiration is indicative of a large cavity, not common in phthisis, but much oftener heard at the upper part of a lung compressed by fluid and air, as in pneumo-hydrothorax.

## RÂLES.

**Râles**, or, as they are termed, *adventitious sounds*, because they have no analogue in the healthy state, cannot be considered as modifications of the normal respiration.

Grouped according to the anatomical situation in which they are produced, we have:—

1. *Laryngeal and tracheal râles.*
2. *Bronchial râles.*

3. *Vesicular râles.*
4. *Cavernous râles.*
5. *Pleural râles.*

Râles may be divided into two groups, according to their character, to wit: *dry* and *moist*, and may be audible either during the act of inspiration or expiration, or during both.

**Dry râles**, for the most part, are produced by the *vibration* of thick fluids which the air cannot break up, and which, therefore, temporarily lessens the calibre of the bronchial tubes. When this narrowing exists in the smaller bronchial tubes the resulting sound is *high-pitched*, or the râle is said to be *sibilant* or *whistling*; when the narrowing exists in the larger bronchial tubes, the râle is *low-pitched*, more musical in character, or *sonorous*.

Dry râles are particularly prone to be dislodged by coughing, and when they are uninfluenced by the acts of breathing or coughing, they do not depend upon the presence of secretions, but upon the narrowing of the air tubes from the pressure of tumors, or from a thickened fold of mucous membrane, or from a spasmodic contraction of the air tubes.

**Moist râles** are those produced by the air passing through thin fluids, such as mucus, blood, serum, or pus, during the respiratory movements. When the fluid exists in the smaller bronchial tubes, the râles are termed *small bubbling*, *mucous*, or *subcrepitant*. When the fluid exists in the large bronchial tubes, the râles are said to be *large bubbling* or *mucous*.

Moist râles are not persistent, but vary in intensity, and shift their positions as the air drives the liquid which occasions them before it, or during violent attacks of coughing, or after copious expectoration.

**Laryngeal and tracheal râles** are those produced within the larynx and trachea, and may be either moist or dry. The moist or bubbling sounds, produced when mucus or other liquids accumulate in this part of the air tubes, frequently occur in the moribund state, and are then known as the "death rattles." When not due to this condition, they denote either insensibility to the presence of liquid, as in stupor or coma, or inability to remove liquid by the acts of expectoration, as in croup or inflammation of these parts in the very feeble.

*The dry râles* produced within the larynx or trachea are generally

caused by spasm of the glottis, to wit: laryngismus stridulus, whooping cough or croup, or from the presence of a foreign body in the part.

Bronchial râles, resulting from the passage of air through the thin liquid, occasion bubbling sounds. When the liquid is present in the larger-sized bronchial tubes, the râles are said to be *large bubbling*, or large mucous râles, and are heard in acute or chronic bronchitis.

When the liquid is in the smaller bronchial tubes, the resulting râle is called *small bubbling*, small mucous, or *subcrepitant*, also occurring in acute or chronic bronchitis.

Bronchial râles due to the narrowing of the tube by its spasmodic contraction, or to the presence of tough, tenacious mucus, which is set in vibration by the passage of the air through the bronchial tubes, are termed dry bronchial râles. Frequently they are suggestive of certain familiar sounds, such as snoring, cooing, humming or wheezing, or they are often musical notes. When produced in the smaller bronchial tubes, they are termed *sibilant*, or high-pitched râles: when produced in the larger bronchial tubes, they are termed *sonorous* or low-pitched râles. They principally occur in the dry stage of bronchitis, or during an asthmatic paroxysm.

The *vesicular râle*, or, as it is more commonly termed, the *crepitant râle*, is produced within the air vesicles or at the terminal portion of the smaller bronchial tubes.

It is to be distinguished from very fine bubbling sounds, or the sub-crepitant râle. "It is a very fine sound, or rather series of very fine uniform sounds, occurring in puffs and limited to inspiration." It resembles the noise occasioned by throwing salt on the fire, or alternately pressing and separating the thumb and finger, moistened with a solution of gum arabic, and held near the ear, or rubbing together a lock of dry hair near the ear.

The *crepitant râle* is produced by the movement of fluid in the air cells or in the finest extremities of the bronchial tubes, or by the forcing open, during the act of inspiration, of the air cells agglutinated by exuded lymph. These sounds may be defined as being very fine, dry, crackling sounds, heard at the end of inspiration. They are usually present in the first stage of pneumonia, and when limited to the apices, are significant of the incipient stage of phthisis.

**Cavernous râles**, or, as they are commonly termed, gurgling

râles, are produced in a pulmonary cavity of considerable size, containing a large amount of liquid communicating freely with a bronchial tube. The sound is occasioned by the agitation of the liquid within the cavity, and may be compared to the sound produced by the boiling of liquid in a flask or large test tube. The sound is sometimes high-pitched or musical, whence it has been termed "amphoric gurgling," but it is generally low in pitch. The râle is heard almost exclusively during the act of inspiration, and its diagnostic importance relates to the advanced stage of phthisis.

**Pleural râles** may be either dry or moist.

*Dry pleural râles*, or, as they are more commonly termed, *friction sounds*, are occasioned when the surfaces of the pleuræ are covered with a glutinous substance preventing the unobstructed movements of the pleural surfaces upon each other during the respiratory acts, for in health these movements occasion no sound whatever. The sounds are generally interrupted or irregular, occurring during the act of inspiration or expiration, or during both acts. The character of the sound is variable, being termed rubbing, grazing, rasping, grating or creaking, according to the intensity of the respiratory acts and the amount of exudation.

They are distinguished by the apparent nearness of the sound to the ear, and are usually intensified by firm pressure of the stethoscope upon the chest. When the chest is fixed, especially at the lower two-thirds, and the ear applied over the seat of the sound, it will be found to have disappeared. This sound is diagnostic of the first stage of pleurisy.

**Moist friction** sounds are produced in the same manner as those just mentioned, the exudation being softened in character. This sound is frequently confounded with moist bronchial râles, and its discrimination is often only positive by a careful study of the symptoms and concomitant signs present.

**Metallic tinkling** is a sign of a pneumo-hydrothorax with perforation of the lung, and when found is usually diagnostic of this affection, although it occurs rarely in cases of phthisis with a large cavity, the physical conditions for its production being similar to those in pneumo-hydrothorax, to wit: a space of considerable size containing air and liquid, the space communicating with the bronchial tubes.

It consists of a series of *tinkling sounds*, of high pitch, silvery or metallic in tone, and is very well imitated by dropping a small marble

into a metallic vase. It occurs irregularly, not being present with every act of breathing, and may be produced by forced, when not heard during tranquil breathing.

Were it not for the location and the absence of concomitant signs, it might be confounded with tinkling sounds sometimes produced within the stomach.

### THE VOICE IN DISEASE.

The normal vocal resonance, as heard over the third rib of the chest anteriorly on either side, may have its *intensity*—

1. *Diminished or absent.*
2. *Increased or exaggerated.*

Or its resonance may be of the character of—

3. *Bronchophony.*
4. *Pectoriloquy.*
5. *Aegophony.*
6. *Amphoric voice.*

The vocal resonance may be diminished or feeble in bronchitis with free secretion, pleurisy with effusion, or in complete consolidation of the lung structure and the bronchial tubes.

The vocal resonance is absent in pneumothorax and in pleurisy with effusion.

Exaggerated vocal resonance differs from the normal vocal resonance in a slight increase of its density. It denotes a slight degree of solidification of lung tissue, and is chiefly of value in the diagnosis of tubercle.

**Bronchophony**, or the voice concentrated near the ear, raised in pitch and in intensity, denotes complete consolidation of the pulmonary tissue in those parts in which the sound is abnormally present.

**Pectoriloquy** is complete transmission of the voice to the ear, the articulated words being distinctly recognized. It has a close resemblance to the resonance heard over the larynx in health. Its presence indicates either a pulmonary cavity or more complete consolidation—in other words, an exaggerated bronchophony.

**Aegophony** is a modification of bronchophony, consisting in tremulousness of the voice, its character nasal or bleating, somewhat suggestive of the cry of a goat. When heard, it may be considered a sign of pleurisy with slight effusion, or of pleuro-pneumonia.

**Amphoric voice**, or "the echo," as it is sometimes called, is a musical sound, of a somewhat hollow, metallic character, like that

produced by blowing into an empty bottle. It is sometimes produced in large cavities within the lung, but is especially incident to pneumothorax.

**Increased bronchial whisper** is a sound in which the whispered words are abnormally intense, and higher in pitch than the normal bronchial whisper. It has the same significance as exaggerated vocal resonance.

### SUCCUSION.

**The succussion** or splashing sound is pathognomonic of one affection, namely, pneumo-hydrothorax.

It is obtained by jerking the body of the patient with a quick, somewhat forcible movement, the ear being very near or in contact with the chest.

The sound is like that produced when a small keg, partially filled with liquid, is shaken. The only liability to error is in confounding this splashing sound with that sometimes produced within the stomach; but attention to concomitant signs and the symptoms will always protect against this error.

### ASSOCIATION OF THE PHYSICAL SIGNS (DA COSTA).

"As many of the signs elicited by the various methods of physical diagnosis depend on the same physical conditions, they may be studied in groups. The following will be usually found to be associated :"—

PERCUSSION.	AUSCULTATION OF RESPIRATION.	AUSCULTATION OF VOICE.	VOCAL FREMITUS.	PHYSICAL CONDITIONS.
Clear .....	Vesicular murmur or its modification.	Normal vocal resonance.	Unimpaired.	Lung tissue healthy or nearly so; at any rate, no increased density from deposits, etc.
Dull ... .....	Bronchial, or harsh respiration.  Absent respiration.	Bronchophony.	Increased.	Solidification of pulmonary structure.
		Absent voice.	Diminished or absent.	Effusion into pleural sac.
Tympanic.	Cavernous or feeble, according to cause.	Uncertain ; cavernous or diminished.	Uncertain ; mostly diminished.	Increased quantity of air within the chest, due to a cavity or to overdistension of the air cells.
Amphoric or Metallic. Cracked metal sound.	Amphoric or metallic.	Amphoric or metallic.	Mostly diminished.	Large cavity with elastic walls.
	Cavernous respiration.	Cavernous respiration.	Uncertain.	Generally a cavity communicating with a bronchial tube.

## DISEASES OF THE NASAL PASSAGES.

### ACUTE NASAL CATARRH.

**Synonyms.** Acute rhinitis; acute coryza; "cold in the head."

**Definition.** An acute catarrhal inflammation of the mucous membrane (pituitary or Schneiderian membrane) lining the nose and the cavities communicating with it; characterized by feverishness, feeling of fullness and discomfort in the head, and attended with discharges of fluid, watery, mucus, or muco-purulent in character.

**Pathological Anatomy.** *Hyperæmia* of the mucous membrane, attended with redness, swelling and deficient secretion. This tumefaction is partly increased by an *œdematous infiltration*, causing a quantity of colorless, salty and very thin liquid to flow from the nose. The secretion soon assumes the character of thick, tenacious mucus or muco-pus, due to the desquamation of the epithelium of the nasal mucous membrane, and a copious generation of young cells, the hyperæmia and the swelling of the membrane diminishing.

The respiratory portions of the nasal fossæ are more markedly affected than are the olfactory.

Rarely, and then in new-born infants and those affected with the eruptive fevers, the exudation in the nasal passages is of a fibrinous nature, somewhat similar to that observed in diphtheria.

**Causes.** Atmospheric changes are the most frequent and influential. Exposure of the neck to a draught of cold air, or of the feet and ankles to cold and dampness, or changing from a warm to a cold atmosphere suddenly, are among the most usual causes.

Irritating gases and vapors, dust, certain powders, as ipecac and tobacco, excite an irritation of the nasal mucous membrane. The scrofulous taint and the rheumatic diathesis seem to render the mucous membrane susceptible to frequent attacks.

Acute coryza is usually present in the initial stage of measles and influenza.

Epidemic influence occasionally prevails on an extensive scale. The poison of syphilis or the use of the iodide of potassium not unfrequently act as exciting causes.

At times the catarrh seems to spread by contagion.

**Symptoms.** "A cold in the head" is usually preceded by a feel-

ing of *lassitude* or weariness and more or less frontal *headache*; then occur irregular *chilly sensations* in the back, followed by more or less *feverishness* and an uncomfortable feeling of *dryness* in the nares, with a strong inclination to *sneeze*. This is soon followed by an abundant *watery and saline discharge*, which is continually dripping from the nostrils, or occasions an attack of sneezing followed by blowing the nose, which relieves the congested and swollen membrane for a few moments. The relief is temporary, however, the fullness of the head and difficult obstructed nasal respiration rapidly returning. *The anterior nares are red and inflamed*, and the eyes red and suffused with tears, through partial or entire closure of the tear ducts. The *discharge* soon assumes a *purulent character*. The *voice* has a peculiar tone, rather nasal and muffled in character. Within a few days the swelling subsides, the secretion lessens, health being restored in about ten days from the beginning of the attack.

When the attack has almost terminated hard crusts may form within the nostrils, either on the septum or turbinated bones, which are with difficulty expelled by blowing the nose.

**Complications.** Irritation and swelling of the upper lip, from repeated blowing of the nose and the constant contact of the irritating discharge.

Extension of the catarrh to the *ethmoid* or *sphenoid cavities* or *frontal sinus*, causing increased and severe frontal headache; or to the *antrum of Highmore*, causing tenderness over one or both cheeks.

Extension to the *Eustachian tube* and *middle ear*, causing impaired hearing; or to the *pharynx* or *larynx*, causing cough.

**Duration.** In mild cases about one week; severe cases continue, more or less marked, for two weeks.

**Prognosis.** Favorable if early and proper treatment be instituted; if neglected, the catarrh tends to become chronic. In very young infants, if the catarrh is not rapidly relieved, loss of flesh and strength occur, from inability to take the breast.

**Treatment.** Attacks the result of atmospherical causes may be aborted by the early administration of *quininae sulphas*, gr. x-xv, with *morphinæ sulphas*, gr.  $\frac{1}{4}$ , or the early use of *pulvis ipecacuanhae et opii*, gr. v repeated every two hours.

The following *errhine* used at the very onset has proved successful in aborting many cases:—

R. Aluminis,  
Bismuthi carb.,  
Pulv. talc, . . . . . aa . . . . . gr. xx  
Morphinæ hydrochlor., . . . . . gr. ij.  
M. et ft. chart. No. xx.

SIG.—Insufflate one powder in each nostril after clearing the nose.  
(Sajous.)

If the attack has already developed, relief is soon afforded by *tinctura belladonnæ*, gtt. ij every hour until six doses are taken, after which one drop every two or three hours until the physiological actions of the drug are produced; if much fever be present, *tinctura aconiti*, gtt. i-ij, may be added; or the following combination of Dr. Sajous:—

R. Ammonii chlor., . . . . . ij  
Tinct. opii, . . . . . mxxiv  
Sacch. alb., . . . . . 3j  
Aq. camphoræ, . . . . . ad f 3j. M.

SIG.—One teaspoonful in water every hour or two.

An efficient plan of treating acute coryza is by producing free diaphoresis with "Dover's powder," gr. x, repeated, if need be, followed by—

R. Potassii citratis, . . . . . 3 ij-iv  
Syrupi ipecac,  
Tinct. opii camph., . . . . . aa . . . . . 3 ij-iv  
Syr. limonis, . . . . . 3 iv  
Aquæ, . . . . . ad . . . . . 3 iij. M.

SIG.—One or two teaspoonfuls every hour or two.

Attacks of acute rhinitis unaccompanied by febrile reaction are generally promptly aborted by a four per cent. solution of cocaine dropped in the nostrils, repeated every half hour.

With either of the above plans may be added one of the following *errhines*:—

R. Bismuth. subnit., . . . . . 3 vj  
Pulv. acaciæ, . . . . . 3 ij  
Morphinæ hydrochlor., . . . . . gr. ij. M.

SIG.—Every hour or two.—(Ferrier.)

Or—

R. Pulv. cubebæ, . . . . . 3 j  
Bismuth. subnit., . . . . . 3 ij  
Morphinæ muriat., . . . . . gr. ij. M.

SIG.—Used by *insufflation* every two or three hours.

Or—

R. Pulv. fol. belladonnæ, . . . . .  $\frac{3}{4}$ j  
 Pulv. morphinæ sulph., . . . . . gr. ij  
 Pulv. g. acaciæ, . . . . . ad . . . . .  $\frac{3}{4}$ ss.

M.

SIG.—Use, with powder blower, to anterior and posterior nares.  
 (Robinson.)

Acute coryza occurring in infants at the breast is controlled by either one of the following errhines: throw into the nose, with a powder blower, finely powdered *saccharum alba*, or equal parts of finely powdered *saccharum album* and *camphoræ*, or Robinson's errhine of *saccharum alba* and *camphora*, each half ounce finely powdered and *acidum tannicum*, gr. xl.

Attacks of nasal catarrh due to the poison of syphilis should at once be placed upon the proper constitutional treatment.

Attacks of nasal catarrh associated with the eruptive or mild fevers require no special treatment.

It is well to remember that attacks of nasal catarrh occurring in very young children are generally the result of hereditary syphilis, and should be treated accordingly.

### CHRONIC NASAL CATARRH.

**Synonyms.** Chronic rhinitis; chronic coryza.

**Definition.** A chronic inflammation of the mucous membrane lining the nasal passages, with more or less alteration of structure; characterized by a sensation of fullness in the nares, increased secretion and a perversion of the special sense of smell and of hearing.

**Causes.** The result of repeated attacks of the acute variety; inhalation of irritating vapors and dust; syphilis and scrofula.

**Pathological Anatomy.** The mucous membrane of the nares is thickened, of a dark-red, sometimes grayish color, the superficial veins dilated and varicose, often forming polypoid enlargements. In many cases there is ulceration of the structure, with more or less loss of substance; the secretion is thick, tough, of a greenish character, and often very fetid; large collections of dried mucus are often formed upon the turbinated bories and septum.

**Symptoms.** A feeling of fullness in the nares, increase of the secretion, the character being thick and greenish, which, dropping

posteriorly into the pharynx, causes paroxysms of "hawking," which are more marked in the morning immediately after arising.

The special *sense of smell* is more or less impaired, and in many cases, entirely abolished; the *special sense of hearing* is more or less diminished, from an extension of the inflammation to the Eustachian tubes; the *voice* has a peculiar *nasal intonation*.

An almost constant dull *frontal headache*, associated with a feeling of weight, showing the extension of the disease to the infundibulum and frontal sinus.

Sudden changes of temperature cause acute exacerbation of these symptoms, when there is superadded difficult nasal respiration.

If *ulceration* of the nares occur, the discharge has a *fetid odor*. This condition is termed *ozæna*.

From extension of the inflammation to the nasal duct or its obstruction, the tears flow over the malar eminence (*epiphora*), leading to more or less congestion of the eyes.

**Diagnosis.** Hypertrophy of the turbinated bones and nasopharyngeal catarrh are constantly misnamed chronic nasal catarrh. The rhinoscope readily determines the diagnosis.

**Prognosis.** Permanent cure is seldom obtained, the disease being so decidedly chronic and obstinate, the treatment is of necessity protracted, and the majority of patients tire of it before a complete cure is effected.

**Treatment.** If it depends upon diathetic conditions, the cause must be ascertained and treatment directed accordingly.

When no diathetic cause can be determined, attention should be paid to the general health, the secretions constantly attended to, and the diet be nutritious and digestible.

Cleanliness of the nasal passages is of the utmost importance, and is best effected by the *post-nasal syringe*, with either simple or medicated tepid waters, or a cleansing solution, such as Dobell's, to wit:—

R.	Acidi carbolici, . . . . .	gr. j
	Sodii bicarbonat.,	
	Sodii borat., . . . . .	gr. v
	Glycerini, . . . . .	3 <i>j</i>
	Aque, . . . . .	3 <i>j</i>
		M.

SIG.—As a spray or with a proper syringe.

Or the following combination of Dr. Sajous :—

SIG.—Apply with atomizer three or four times daily.

after which decided benefit follows the use of one of the following :—

R.	Hydrargyri chlor. mite, Pulv. aluminis, . . . . .	aa . . . . .	3 ss	
	Morphinæ hydrochlor., . . . . .		gr. ij.	M.
R.	Sodii borat., . . . . .		3 j.	
	Bismuth. subnit., . . . . .		3 ij.	
	Morphinæ muriat., . . . . .		gr. j.	M.

Or—

R.	Iodoformi, . . . . .	3j
	Acid. tannici, . . . . .	gr. v
	Pulv. camphoræ, . . . . .	3j
	Bismuth. subnit., . . . . .	3j.

SIG.—To be used by *insufflation* or as a *snuff*, every three or four hours;

Or—

R.	Ammonii muriat., . . . . .	3 j.
	Glycerini, . . . . .	3 ij.
	Ext. pinus canad. fld., . . . . .	f 3 j.
	Aquam, . . . . . ad . . . . .	f 3 ij.

SIG.—Five to ten drops, dropped into each nostril two or three times a day.

## DISEASES OF THE PHARYNX.

## ACUTE CATARRHAL PHARYNGITIS.

**Synonyms.** Catarrhal tonsillitis; angina catarrhalis; acute "sore throat."

**Definition.** An acute catarrhal inflammation of the mucous membrane of the tonsils, uvula, soft palate and pharynx; characterized by rigors, fever, painful deglutition, coughing, or constant desire to clear the throat, with a more or less decided nasal intonation of the voice.

**Causes.** Exposure to cold and damp; swallowing hot fluids or food; during the prevalence of scarlatina, measles or variola.

**Pathological Anatomy.** The mucous membrane and submucous tissues of the uvula, soft palate, fauces, tonsils and pharynx are congested, red and swollen, the secretion is at first lessened or entirely arrested, later it is increased, but of a thick, tenacious, opaque character. The swelling is most evident at the uvula, due to the amount of relaxed sub-mucous tissue, which is especially thick and long, often resting on the root of the tongue ("the palate is down").

Frequently one or both tonsils are swollen to such an extent that the fauces are completely occluded, and the condition is mistaken for the graver phlegmonous tonsillitis.

In severe attacks of catarrhal angina, white or grayish-white membranous masses, form in small, irregular, roundish spots on the reddened mucous membrane of the tonsils, soft palate and pharynx, causing the affection to be frequently mistaken for diphtheria.

**Symptoms.** The onset is usually sudden, with *rigors, fever, thirst, headache, loss of appetite, coated tongue, bad taste, foul breath, dryness in the throat, painful deglutition, and constant desire to clear the throat*, due to the increased length of the uvula; as the inflammation proceeds the *secretions* are increased, the fluid often filling the mouth and also causing a constant desire to swallow, each act being associated with acute pains. Not infrequently *earache* adds to the patient's distress, from extension of the "catarrh" to the Eustachian tubes and tympanum.

In severe attacks of catarrhal pharyngitis, cases which, from the intense hyperæmia, have been termed *erysipelatous* or *erythematous pharyngitis*, the muscles of the palate are infiltrated with serum, which greatly interferes with their function. Under normal conditions the contraction of the muscles of the anterior half arches of the palate prevents the return of the food and drink into the mouth; while the contraction of the muscles of the posterior half arches, together with the uvula, closes the passage to the nose; if the function of these muscles be impaired, fluids would be driven through the nose or back into the mouth by the contractions of the pharynx in the act of deglutition.

In all affections of the pharynx a *nasal tone* is pathognomonic, especially if the muscles of the half arches are interfered with.

**Varieties.** *Exanthematous Pharyngitis* is the form of the affec-

tion complicating the acute infectious diseases, such as scarlatina, measles and smallpox.

*Erysipelatous Pharyngitis* is the form complicating facial erysipelas, rarely, however, the affection begins in the pharynx, spreading to the face and other parts.

*Gangrenous Pharyngitis* may occur with diphtheria, scarlatina, erysipelas, smallpox and typhoid fever. The symptoms assume a typhoid (depressed) character, the termination being usually fatal.

*Phlegmonous Pharyngitis* is the variety in which is present an accumulation of pus in the submucous and deeper tissues of the pharynx, constituting a *retro-pharyngeal abscess*. This variety of pharyngitis may follow the penetration of a sharp piece of bone or be secondary to caries of the cervical vertebræ.

*Fibrinous Pharyngitis*, or, as it is sometimes termed, *pseudo-membranous*, is considered with croup and diphtheria, of which it constitutes a part.

**Diagnosis.** On account of the great swelling of the tonsils, it may be mistaken for *acute tonsillitis*; but the mild inflammatory symptoms should prevent the error.

Cases with membranous deposits upon the tonsils, soft palate and pharynx are no doubt often misnamed *diphtheria*; the marked difference in the constitutional symptoms should prevent the error.

**Prognosis.** Favorable, the affection terminating in three or four days by the raising of a quantity of thick, opaque mucus.

**Treatment.** Perhaps the most successful treatment of this affection is by *insufflation*, every hour or two, with *sodii bicarbonas*.

*Tinctura opii*, ℥v-x for a dose or two at the very onset of an attack, will often abort the catarrh.

If the inflammatory symptoms are severe, *tinctura aconiti*, gtt. j-ij, at short intervals, is of decided advantage. At times *tinctura belladonnae* may be added.

Locally, *cocaine* painted over the inflamed parts, of the strength of a four per centum solution, or used in the form of lozenges, is a valuable remedy. Holding small pellets of ice in the mouth is useful, as is the application of either heat or cold to the angles of the jaws. *Gargles* or *sprays* of *aluminis* (gr. viij-aquæ fʒj), *ammonii murias* (gr. xx-aquæ fʒj), or *potassii chloras* (gr. xij-aquæ fʒj), used at frequent intervals, often allays the congestion and consequent swelling.

## ACUTE TONSILLITIS.

**Synonyms.** Amygdalitis ; quinsy ; phlegmonous pharyngitis.

**Definition.** An acute parenchymatous inflammation of one or both tonsils, with a strong tendency toward suppuration ; characterized by moderate fever, pain in the throat, a constant desire to relieve the throat, painful and difficult deglutition, impeded respiration, and more or less muffling of the voice.

**Causes.** Generally attributed to exposure to cold, but, in the majority of cases, the exposure is so slight that there must be a predisposition to the affection ; for persons once affected are particularly prone to repeated attacks, upon the slightest exposure.

**Pathological Anatomy.** One or both tonsils will be seen, on inspection, to project from its bed, as a rounded, deep red body, which may even extend beyond the median line, when they may entirely occlude the isthmus of the fauces ; the half arches and posterior border of the soft palate are reddened and somewhat swollen. The surface of the tonsils is often covered with small, yellowish points, which closely resemble patches of false membrane, but careful inspection will show that they are beneath the mucous membrane, being only the distended follicles of the gland. The mucous membrane of the fauces and pharynx is more or less red and swollen.

**Symptoms.** Onset more or less sudden, with *rigors, rise in temperature 102° to 104° F., full, frequent pulse, 100 to 120, headache, thirst, pain and swelling at the angle of the jaw*, with a constant desire to clear the throat, *difficult and painful deglutition*, from the enlarged tonsils almost closing the fauces, when the *respiration* is more or less *impeded* ; the *voice* is more or less *muffled*, and attempts at phonation increase the pain.

Darting pains along the Eustachian tubes are of frequent occurrence, the patient complaining of *earache* and more or less *deafness*.

If *suppuration* be imminent, the throat becomes more *painful*, the character of the pain *throbbing*, the febrile phenomena increase, with more or less *depression*, the symptoms seeming to be of great danger, when suddenly, after an effort at vomiting, or spontaneously, the tonsillar abscess bursts, a quantity of pus escapes from the mouth, and prompt relief follows.

**Duration.** The disease lasts from three to seven days, terminating either by suppuration or the gradual resolution of the enlarged glands.

**Diagnosis.** Tonsillitis can hardly be mistaken for any other affection, if the fauces are inspected.

**Prognosis.** In the majority of cases the result is favorable, it very rarely proving fatal, except in children, and only then by obstructing the respiration, and, at the same time, so seriously interfering with nutrition that the child's strength fails.

**Treatment.** "Instar specifici in hoc morbo operatur," well said Holmes when referring to *guaiacum* in the first hours of a true tonsillitis, for experience has amply proven its power to cut short an attack if administered early. I usually order *tinctura guaiaci ammoniata*, fʒj, in water or milk every hour or two, until its good effects are produced. The drug is all the more successful if at the same time it be used locally in the form of *trochiscus guaiaci* (āā gr. ij) frequently repeated, or the following gargle at intervals of every half an hour to an hour :—

R.	Tincturæ guaiaci ammoniat.,	
	Tincturæ cinchonæ comp., . . . . .	āā . . . . . fij
	Mel. despumati, . . . . .	3 vi-

M. and shake together until the sides of the containing vessel are well greased, then

Add—

M. and add gradually, continuing shaking.

Should the febrile reaction be high, *tinctura aconiti* in small doses frequently repeated, either alone or alternating with guaiacum, rapidly reduces the temperature and the frequency of the pulse, and, by its local action lessens the pain and swelling. If from any cause the internal use of *aconitum* be contraindicated, the *tinctura aconiti* may be diluted with *glycerinum* and painted over the affected parts. The author has seen excellent results follow the use of *sodii salicylat.*, gr. x-xv in solution, every three hours. Prof. DaCosta has seen attacks of acute tonsillitis aborted by prompt *emesis* with *pulvis ipecacuanhae*, gr. xx, also by the early administration of *quininæ sulphas*, gr. xx for an adult, or gr. viij for children.

Cases not seen until two or three days after the onset are benefited by the following :—

R. Tincturæ ferri chlor., . . . . . fij  
Glycerini, . . . . . ad . . . . . fij

SIG.—Teaspoonful every two hours.

This palatable mixture, suggested by Dr. Bosworth, acts as a local astringent in passing over the inflamed tonsils, and should not be followed with water or food for an hour at least.

*Scarification*, a long, sharp bistoury being used to make five or six cuts, affords great relief when the tonsils are much inflamed ; the *external* use of *ice* over the site of the glands, and small pellets allowed to dissolve in the mouth, afford great relief. If the application of cold be objectionable, heat may be substituted in the form of warm compresses or poultices.

In all cases we must also have recourse to such general therapeutic measures as are calculated to guide the morbid action to a favorable issue ; the bowels should be kept open and the skin and kidneys active ; the *diet* should be in the shape of gruels, as it is impossible for the patient to swallow any solid substance, and in cases where even gruels cause painful deglutition, thin oatmeal gruel can be used with advantage.

When *suppuration* cannot be averted, hot applications should be applied to the angles of the jaws, hot gargles and the steam atomizer resorted to, medicated with opium, belladonna, benzoin or cocaine, and as soon as fluctuation can be detected the abscess should be opened. Also during this stage administer *quininæ sulphas*, gr. iij-v, every three or four hours. After the acute symptoms have subsided, assist the return of the glands to their normal condition by the topical application of *cupri sulphas* (gr. xx-aquæ fʒj) or *liquor ferri sub-sulphatis* (fʒj-aquæ fʒj).

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## DISEASES OF THE LARYNX.

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### ACUTE CATARRHAL LARYNGITIS.

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**Synonyms.** Catarrhal laryngitis ; "sore throat."

**Definition.** An acute catarrhal inflammation of the mucous membrane of the larynx ; characterized by feverishness, diminished or suppressed voice, painful deglutition, and more or less difficulty of respiration.

**Causes.** Atmospherical changes ; cold draughts of air whether directly inspired or exposure of parts or all of the body to the same.

Cold, wet feet; inhalation of irritating vapors, such as gas, smoke or ammonia; inhalation of dust. Prolonged efforts at public speaking or singing or the same efforts under difficulties. In children, from violent fits of crying.

**Pathological Anatomy.** In mild cases there is a transient *congestion* (*hyperæmia*) of the mucous membrane over the entire, but more commonly, circumscribed portions of the larynx, with more or less swelling and diminished secretion; the mucous membrane soon returns to its normal condition, the secretion being slightly increased.

**Symptoms.** The attack begins rather suddenly with a feeling of *dryness*, *rawness*, and *tickling*, referred to the larynx with the sensation of the presence of a foreign body in the throat, and with *hoarseness* and a disposition to cough. Deglutition causes pain by the upward movement of the larynx and by the pressure of the food on the larynx as it passes along the gullet. Attempts at speaking are attended with more or less distress and the larynx is tender on pressure.

*Coughing*, from the onset, of a *noisy*, *harsh*, *hoarse*, or *toneless* character and the act of coughing attended with a sensation of scratching in the larynx. The first day or two there is scanty expectoration, but in a short time the secretion is increased, giving the cough a loose character. In the early stages the sputa may be slightly streaked with blood. Rarely a hemorrhage occurs from the mucous membrane of the larynx. The *voice* is at first decidedly *hoarse*, soon followed by complete *aphonia*. The *respiration* is but slightly, if at all, affected in adults. There may be more or less febrile reaction. In *children* the onset is with *fever*, *white coated tongue*, *frequent*, *tense pulse*, *hot skin* and *flushed face*, embarrassed respiration; the voice *hoarse* and *whispering* with *harsh*, *ringing*, *croupy cough* and great restlessness. During the night the child is subject to suffocative attacks (*laryngismus stridulus*).

**Laryngoscopic appearances.** These vary with the severity of the attack and the stage of the inspection. *Mild cases*, at an early period, the mucous membrane presents a bright red appearance. *Severe cases* present, in addition to the bright redness, the mucous membrane swollen, to such an extent at times as to conceal the vocal cords, they appearing only as slender threads of a reddish tint. At times the mucous membrane presents the appearance of erosions or ulcerations, due to a desquamation of the epithelium.

**Duration.** Usually about one week; if very severe, two or three weeks may elapse before the larynx returns to its normal condition.

**Prognosis.** Simple catarrhal laryngitis never terminates fatally.

**Treatment.** Confinement to an apartment of uniform temperature, the air kept moist by the vapor of water being disengaged in it, and particularly in the case of children.

Locally, a hot pack should be kept constantly wrapped about the throat, and if its application is preceded by the temporary use of a weak mustard plaster, the relief afforded is more rapidly obtained. At the very beginning of an attack the feet should be placed in a hot mustard foot bath, and a saline cathartic administered.

Prompt action on the skin at the very onset will frequently shorten the duration of a catarrh of the larynx. Use for this purpose in adults, *pulvis ipecacuanhæ et opii* (gr. iij) combined with *potassii nitras* (gr. iij) every three or four hours. If there be much febrile reaction benefit follows the use of *tinctura aconiti* m<sub>j</sub>-ij every half hour until five or six doses are taken, after which every hour or two, combined with *tinctura opii* m<sub>j</sub>-v; or diaphoresis may be produced by *antimonii et potassii tartras*, gr.  $\frac{1}{20}$ - $\frac{1}{30}$  every hour, or by a hypodermic injection of *pilocarpus murias* gr.  $\frac{1}{3}$ .

For children, several doses of the following powder a couple of hours apart, until the bowels are freely moved,—

R.	Hydrargyri chloridi mite,	gr. $\frac{1}{8}$
	Pulvis ipecacuanhæ,	gr. $\frac{1}{8}$
	Sacc. lac.,	gr. ij.

to be followed by the following :—

R.	Potassii citrat.,	ʒ iv
	Tinct. aconiti,	m <sub>j</sub> iv
	Tinct. opii camphorat.,	ʒ ij-iv
	Syr. scillæ,	ʒ ij
	Syr. tolu,	ʒ ij.

M.

SIG.—One teaspoonful every two hours.

If a tendency to spasm of the glottis obtains, full doses of the *bromides* should be administered at once.

Inhalations from the onset are not only soothing but curative in their actions. Either of the following are recommended :—

R.	Infusi humulus,	0j
	Vinegar,	f ʒ ss-j.

M.

SIG.—Inhale hot every hour.

R. Tinct. benzoin comp., . . . . . fʒj-ij  
 Aque bull., . . . . . Oj. M.  
 SIG.—Inhale hourly.

The local application of cocaine is of great benefit.

Attacks of acute laryngitis occurring from efforts in public speaking or singing are wonderfully benefited by the use of *acidum nitricum dilutum*, mlij-v, every hour or two.

The patient should abstain altogether from the use of the voice and from taking food or drink of an irritating character.

### ŒDEMATOUS LARYNGITIS.

**Synonym.** œdema of the glottis.

**Definition.** An acute inflammation of the mucous membrane of the larynx and that about the glottis, with an infiltration of the areolar tissue by a serous, sero-purulent or purulent fluid; characterized by obstructed or stridulous breathing and dysphonia or aphonia.

**Causes.** The result of acute laryngitis; abscess in or about the throat or tonsils; erysipelas of the face; scarlatina; smallpox; Bright's disease. Rare in children.

**Pathological Anatomy.** Infiltration into the loose connective tissue of the ary-epiglottic folds, the glosso-epiglottic ligament, the base of the epiglottis, and the inter-arytenoid space. If the true vocal cords are inflamed, their color changes, and instead of appearing white, glistening and brilliant, they are dull, grayish-red or violet-red in patches. If the swelling be the result of purulent infiltration, the parts affected present a deeply congested color, with here and there spots of a yellowish hue.

Serous infiltration, sufficient to cause fatal œdema, disappears with death, leaving but slight traces to account for the formidable symptoms.

**Symptoms.** The onset is much the same as a simple catarrhal laryngitis with a gradually *increasing impediment to the respiration*. The patient experiences the sensation of a foreign body in the throat, and after a short time a *difficulty of breathing*, which ultimately threatens *suffocation*. The *deglutition* is rendered difficult owing to the swelling of the epiglottis; the *voice*, at first muffled, gradually becomes weaker and weaker, until finally it is almost extinct; the *cough* at first is dry and harsh, but as the infiltration increases it

becomes stridulous and suppressed ; there is no expectoration except that after great effort to clear the throat, a little frothy mucus is raised. The *difficulty of respiration*, as the disease progresses, becomes greater and greater, and the *paroxysms of impending suffocation* more frequent. The inspiration is accompanied by a whistling sound, characteristic of the narrow condition of the glottis, the patient sits up in bed, his mouth open, gasping for breath, his eyes protruding, the whole body trembling with intense convulsive movements, and after a time a general cyanosis commences, the face assuming a bluish hue, all these symptoms continuing for a few moments, when slight relief occurs, to be again followed by another paroxysm, in one of which, if nature or art does not afford prompt relief, death occurs from asphyxia.

*A physical examination* of the parts may be made by gently passing the finger into the throat, when the epiglottis may be felt very much thickened, and the ary-epiglottic folds may have attained such tumefaction as to convey to the finger an impression similar to that which is given by touching the tonsils.

*Laryngoscopic appearance.* The mucous membrane has a bright red appearance. The epiglottis has the appearance of a semi-transparent roll-like body, or it is often merely erect and tense. It is this condition of the epiglottis which explains the pain and difficulty in deglutition. Rarely the vocal cords are infiltrated.

**Diagnosis.** Any disease which gives rise to dyspnœa, may simulate oedematous laryngitis, but the history of the case and the laryngoscopic examination will generally furnish conclusive evidence as to the real nature of the malady.

**Prognosis.** As a rule unfavorable. If early and vigorous treatment be instituted, recovery is possible, but without it death is the inevitable result, the patient dying asphyxiated. Even when local measures have removed the obstruction to free respiration, the patient is very likely to perish subsequently from exhaustion, or blood poisoning, or from pneumonia or other lung complication. The duration of infiltration of the larynx varies from a few hours to several days.

**Treatment.** Prompt local treatment must be adopted in order to remove the laryngeal obstruction. *Leeches* placed over the sides of the larynx in mild cases may effect so much reduction in the oedema as to render the subsequent progress of the case free from danger.

If the *infiltration* has already occurred and is slight in amount,

scarification, guiding the instrument by the index finger of the opposite hand, may afford relief, or the hypodermic injection of *pilocarpine murias*, gr.  $\frac{1}{3}$ , repeated, may lessen the swelling.

Niemeyer recommends the persistent use of small pellets of ice swallowed or held far back in the mouth till dissolved, early in the attack. Trousseau recommends the *inhalation* or *spray* of a strong solution *acidum tannicum*. Prof. DaCosta suggests the application as near the seat of the disease as possible of *liquor ferri subsulphatis* (Monsell's solution), full or half strength. Mackenzie says the patient should be kept constantly under the influence of *potassii bromidum*.

If these means fail, *tracheotomy* is indicated; in those cases of sudden and rapid infiltration of the glottis or larynx occurring in Bright's disease, erysipelas or scarlatina, and especially the former, *tracheotomy should be performed at once*.

In all cases of infiltration of the larynx stimulants should be boldly administered per rectum, if stomachic administration be impossible.

If the infiltration be composed of *pus*, *quinince sulphas.*, gr. v, every four hours, and stimulants are indicated.

### SPASMODIC LARYNGITIS.

**Synonyms.** Spasmodic croup; false croup; catarrhal croup; child-crowing.

**Definition.** A catarrhal inflammation of the mucous membrane of the larynx, associated with *spasmodic contraction* of the glottis; characterized by paroxysmal coughing, difficulty of breathing and attacks of threatening suffocation.

Mackenzie describes it as "a form of convulsion occurring in ill-nourished infants, characterized by spasmodic action of the abductors of the vocal cords, and in severe cases by spasm of the diaphragm and intercostal muscles."

**Causes.** Delayed or difficult dentition; excesses in eating and drinking; excitement; violent emotion and atmospherical changes, are all given as causes for simple croup. It is often hereditary.

**Pathological Anatomy.** Congestion of the mucous membrane of the larynx, with slight swelling and deficient secretion, are the only changes that have thus far been noted.

**Symptoms.** The attack occurs chiefly during the *night*, the child on retiring having either its usual health, or, perhaps, being a little fever-

ish. After several hours of sleep the child is suddenly awakened by a *paroxysm of suffocation*, and a dry, harsh, ringing cough. After half an hour or an hour or two the breathing becomes easier, the cough less "croupy," the skin is covered with more or less perspiration, and the child falls asleep. The next day there is present cough of a loose character, the respiration being about normal. If no treatment be instituted, the same phenomena occur on the second night, the child being apparently well during the second day, the cough being less in amount; phenomena of a similar character, but of much less severity, are present the third night, after which the disease usually disappears.

If the symptoms of the first paroxysm continue pronounced for two or three days, there is a strong probability that the inflammation may become fibrinous in character, or that true croup may develop.

**Diagnosis.** The symptoms are so characteristic that it seems impossible for the affection to be mistaken for any other disease.

**Prognosis.** Spasmodic or simple croup always terminates favorably.

**Treatment.** During the paroxysm, the child should at once be placed in a hot bath and hot or cold compresses wrapped about the throat. These means should be preceded or followed by a mild emetic. The late Chas. D. Meigs always used *aluminis*, with or without *syr. ipecacuanhæ*; Prof. Barker recommends *hydrargyri sulphas flava* (turpeth mineral), gr. i-iij; Prof. DaCosta suggests the cautious use of *apomorphia*, gr.  $\frac{1}{10}$  hypodermically. A favorite remedy for emesis, in Germany, when the jaws are not closed, and one that is highly successful, is tickling the fauces with the finger or a feather until vomiting is produced. Inhalations of *chloroformum* often at once relieve the spasms, but must never be employed by non-professional persons. Having by any of the above means broken up the attack, *nausea* and *diaphoresis* should be maintained by the following combination :—

R. Extract. ipecacuanhæ fluid., . . . . .	m xij-xxiv
Tinct. opii camphoratæ, . . . . .	f 3 ij-iv
Liq. potassii citratis, . . . . ad . . . .	f 3 ij.

M.

SIG.—One teaspoonful every two hours.

To ward off further spasms, no one remedy equals *potassii bromidum*, gr. v-xv every three or four hours, or *chloral*, gr. v at bedtime.

Mackenzie advises the use of *musk* during the attack if the child can swallow; and if not, then as soon as the child can take it, and continued at intervals for a day or two. His formula is as follows:—

R. Moschi,	gr. iss	
Sacch. alb.,	gr. ij	
Pulv. acacie,	gr. ij	
Syr. aurantii flor.,		
Aquam, . . . ää . . . ad . . . . .	3j.	M.

SIG.—A dose.

The *air* of the room should be *moistened* by the vapor of steam constantly disengaged in it.

After the attack has passed off, the general condition of the child must be attended to; for this purpose it is well to administer a dose of *hydrargyri chloridum mite*, to be followed by a dose of *oleum ricini* or *magnesii carbonas*. The diet must be regulated, all farinaceous articles being absolutely forbidden.

### CROUPOUS LARYNGITIS.

**Synonyms.** Membranous croup; true croup.

**Definition.** An acute inflammation of the mucous membrane of the larynx, attended with the exudation of a tough secretion—the *false membrane*—and the occurrence of *spasm of the glottis*; characterized by febrile reaction, frequent ringing cough, dyspnœa, with loud inspiratory sound, and altered or extinct voice, showing a strong tendency toward death by asphyxia.

**Causes.** A disease of childhood, most common in strong, vigorous, well-nourished males. Certain families present a strong, hereditary tendency. Most common during a humid winter.

We cannot assent to the dictum of some authorities, that laryngeal diphtheria and croupous laryngitis are identical.

**Pathological Anatomy.** Intense *hyperæmia* of the mucous membrane of the larynx, associated with *swelling*, *œdema* and marked *redness*. There soon appears on the surface of the mucous membrane a grayish pellicle, rapidly coalescing and becoming thicker—the *opaque, false membrane*—which differs in extent, thickness and adhesiveness in different portions of the larynx. In all cases the false membrane is found on the vocal cords and inner surface of the epiglottis. The first *exudation* (membrane) softens by the serum

which is exuded, and is then mechanically dislodged by acts of coughing or vomiting, but is followed by successive deposits upon the mucous membrane.

When the false membrane is detached the mucous membrane of the larynx is found unaffected, so far as the loss of structure is concerned. Several successive crops of membrane may occur after the detachment, or it may entirely cease to form after the removal of the first exudation.

On microscopical examination the false membrane is found to be composed of a fine network of fibrillæ, holding in their interstices leucocytes of an albuminous or fibrinous nature.

The false membrane may extend into the pharynx, but especially is it liable to extend into the trachea and bronchial tubes, and, as the inflammation extends downward, the character of the exudation changes from fibrinous to muco-purulent.

**Symptoms.** The onset of "true croup" is either suddenly, by an attack of spasmodic croup, or gradually, as an acute catarrh of the larynx, rapidly increasing in severity, with a feeling of *heat* in the throat, *huskiness* of the voice, *harsh cough*, *fever* and *thirst*, the hoarseness soon becoming marked, and the *cough* having a *metallic*, "*croupy*" character, rapidly *changing* to a *stridulous*, *husky* sound; every few minutes the child takes a sudden, deep *stridulous inspiration*, the voice becoming more and more husky. *Difficulty of breathing* now follows, the child is unable to lie down, or if, exhausted by the efforts at inspiration, it is quiet for a moment, it soon starts up in fright, breathing more heavily, with a *shrill, whistling inspiration*. Soon, from the narrowing of the glottis, from the presence of the membrane, the expiration becomes difficult and noisy, and *suffocation* seems imminent, from the *paroxysmal* attacks of *spasm of the glottis*, when the child tosses wildly about, tears at its throat, as if to remove some obstacle, the face becoming *cyanosed*, the alæ of the nose working rapidly, the mouth wide open, the inspiratory efforts gasping, the body covered with a profuse sweat, and death seems imminent, when the spasm is relaxed, air enters the chest, the breathing becomes somewhat easier, and the child, exhausted and partially stupefied, drops into a fitful sleep of a few moments' duration.

The *suffocative attacks* return at short intervals, or there occur decided remissions between them, considerable portions of the false membrane being expelled, when the child falls into a refreshing sleep.

In those cases which tend to a favorable termination, the appearance of improvement noted between the suffocative attacks is maintained, the paroxysms of suffocation becoming less frequent, the expectoration of membrane more marked, the difficulty of breathing lessens, the cough looser, the voice gradually returning, the fever, which has been more or less high during the attack, disappearing.

If, instead of improvement, the case tends toward a fatal termination, the suffocative attacks become more frequent, expectoration is absent, the voice and cough inaudible, although the efforts at speaking and coughing are visible, the difficulty of breathing continues, the respirations becoming more frequent and shallow, but without whistling and stridor, cyanosis deepens, the countenance has an indifferent, drowsy and stupid look, the eyes dull and nearly closed, with symptoms of depression, the pulse rapid and weak, the surface covered with a cold, clammy sweat, the extremities cold, stupor and insensibility more marked, the child dying of carbonic acid poisoning or *asphyxia*.

**Duration.** The duration of true croup is about one week, rarely continuing ten days.

**Diagnosis.** *Edema of the glottis* may be mistaken for croup until the period of the formation of the characteristic membrane. The chief points of distinction from the onset are, however, absence of fever, paroxysmal attacks of difficult respiration, followed by a complete return to the normal condition.

*Laryngeal diphtheria* differs from true croup in its history, its epidemic character, the marked depression, even before obstruction of the larynx produces imperfectly aerated blood, the presence of albumin in the urine, and the sequelæ.

**Prognosis.** A very fatal disease. The danger is great in proportion to the age and feebleness of the child.

The *unfavorable symptoms* are: Loud, stridulous, inspiratory and expiratory sounds, laborious and prolonged expiration, depression of the base of the thorax during inspiration, whispering voice or complete aphonia, congestion of the face and neck, stupor, weak, rapid and irregular pulse, cold extremities, and a cold, clammy perspiration.

The *favorable symptoms* are: Expectoration of false membrane, decrease of the stridulous respiration, voice changing from whispering to hoarseness, looseness of the cough, moderation of the fever, and an improvement in the general condition.

**Treatment.** The indications for treatment are to detach and remove the false membrane, to prevent its formation, to prevent the attacks of spasm of the glottis, and to maintain the strength.

To detach and remove the membrane emetics are of the highest utility, the favorite of this class being the one first used in this disease by Dr. Fordyce Barker, consisting of *hydrargyri sulphas flava* (turpeth mineral), gr. ij for a child of two years of age, repeating the dose as often as rendered necessary by the obstructed breathing; but the unnecessary administration of emetics should be avoided, as the strength of the patient must be maintained.

To prevent the formation of the membranous exudation a number of remedies have been recommended and highly lauded by their respective proposers. If seen early, as the fever and husky voice are developing, *tinctura aconiti*, m.  $\frac{1}{4}$ -j, every fifteen minutes, and *quininæ sulphas*, gr. ij-v, every hour until cinchonism is produced, are of unquestionable utility; another plan strongly urged is with *ammonii bromidum* in full doses alternated with *quininæ sulphas*, gr. iij-v, every three hours; still another and popular remedy is *hydrargyrum*, which is certainly one of the most reliable agents we possess; it may be used as *hydrargyri chloridum corrosivum*, gr.  $\frac{1}{8}$ - $\frac{1}{24}$ , every two or three hours, or in the following formula:—

R.	Hydrargyri chloridi mite,	gr. $\frac{1}{8}$ - $\frac{1}{4}$ - $\frac{1}{2}$
	Sodii bicarbonat.,	gr. ij
	Pulvis ipecac,	gr. $\frac{1}{12}$ - $\frac{1}{6}$ . M.

SIG.—One powder every two hours.

Prof. DaCosta suggests either of the following combinations:—

R.	Antimonii sulphurati,	gr. $\frac{1}{8}$
	Pulv. opii et ipecacuanhæ,	gr. $\frac{1}{2}$ . M.

SIG.—In powder every two hours.

Or—

R.	Hydrargyri chloridum mite,	gr. $\frac{1}{8}$
	Pulvis opii et ipecacuanhæ,	gr. $\frac{1}{2}$ . M.

SIG.—In powder every two hours.

*Antimonii et potassii tartras*, a remedy that some years ago was popular in large doses, is again brought forward in doses of gr.  $\frac{1}{30}$ - $\frac{1}{20}$ . *Quininæ sulphas*, gr. v, every three hours until six doses have been taken, if given before the exudation has formed, it is claimed will prevent its formation.

To prevent the paroxysms of spasm, small doses of *opium* in the form of *pulvis ipecac et opii* (Dover's powder), or full doses of the *bromides*, preference being given to *ammonii bromidum*, as suggested by Prof. Bartholow, on account of its being "eliminated by the bronchial and faecal mucous membrane, thus acting locally."

To maintain the strength of the patient, *alcoholic stimulants* in full doses, nutritious but easily digested *aliment*, *quinina* in tonic doses, and *ammonii carbonas*, are particularly indicated.

*Locally*, the use of all caustic or irritating applications to the fauces or larynx is emphatically contraindicated.

The *inhalation* of the vapor of slaked, freshly burned lime is one of the most ready and efficient means for assisting in the detachment of the false membrane. The application of *cold or hot compresses*, according to the feelings of the patient, around the throat, have a strong tendency to prevent the recurrence of the spasms. After the formation of the membrane, great relief follows the use of the vapor inhalations and oxygen gas, which with stimulants and liquid nourishment may safely carry the patient through the disease. Cases in which the membrane presents a tendency to slowly loosen itself, if the patient's strength does not contraindicate it, are greatly benefited by the application of *sinapis*, or even small *flying-blisters*, to the larynx.

Niemeyer advises in cases showing carbonic acid poisoning from obstruction of respiration due to accumulation of membrane, the pouring from a moderate height of a few gallons of cold water over the head, nape and back of the child; the shock produced always causes it to revive for a while, and to cough vigorously, thus expectorating large quantities of the membrane.

Relief from the obstructed respiration is obtained and the affection beneficially influenced by the use of "O'Dwyer's tubes."

If the exudation still continues, regardless of the means employed, the propriety of *tracheotomy* must be decided.

### LARYNGISMUS STRIDULUS.

**Synonyms.** Spasm of the glottis; pseudo-croup; "Kopp's asthma."

**Definition.** A temporary spasm of the muscles of the larynx innervated by the inferior or recurrent laryngeal nerves; character-

ized by a sudden development of dyspnœa and the appearance of deficient oxygenation of the blood.

**Causes.** Most common in children, the result of teething, laryngitis, indigestion, scrofula or other cachexia. Attacks in adults are not uncommon.

**Pathological Anatomy.** Death the result of spasm of the glottis is such a very rare occurrence that the changes in the larynx are illly understood.

The mechanism consists in an irritation of the superior laryngeal nerve—the afferent nerve—whose function is to apply the mucous lining of the larynx with sensibility, whence is reflected through the inferior laryngeal nerve—the efferent nerve—the motor influence resulting in the spasm of the laryngeal muscles.

**Symptoms.** The spasm of the laryngeal muscles is of sudden onset, and usually after nightfall. The child may have been in perfect health, to all appearances, on retiring, or it may have shown symptoms of catarrh of the upper air passages, or been suffering from gastro-intestinal or dental irritation.

The child awakes suddenly, *coughing* in a metallic, resonant tone—the *croupy cough*—and with great *dyspnœa*, with *loud, crowing, stridulous inspirations*, the result of narrowing of the larynx from spasm, with *wheezy, stridulous expirations*.

The entrance of air is so greatly obstructed that all the accessory muscles of respiration are called into use, the lips and finger nails become blue, the surface cold, the countenance anxious, and the inferior portion of the chest is drawn in, instead of being expanded, during inspiration. General *convulsions* occur at times, during a paroxysm, also *strabismus*, and involuntary discharge of the fæces and the urine.

The paroxysm continues from half an hour to an hour or more, to return after a few hours' sleep, or during the following night; the cough, during the day, has the croupy character.

**Diagnosis.** The non-febrile and distinctly intermittent nature of the affection differentiates it from croup, and its own distinctive characters, from all other diseases.

**Prognosis.** Favorable. Death from suffocation during the paroxysm, may occur in very young children, but it is certainly a very rare termination.

**Treatment.** For the *paroxysm*, the inhalation of a few drops of

*chloroformum* is the most prompt method, due care being exercised; complete anaesthesia is unnecessary. Success is reported from the prompt inhalation of *amyl nitris*, also from *nitro-glycerinum*, in small, but frequently repeated doses; the following combination is a prompt antispasmodic :—

R.	Potassii bromidi,	3 ij	
	Chloral,	gr. xxxij	
	Syr. aurantii corticis,	fʒj	
	Aquæ menth.,	fʒj.	M.

SIG.—One teaspoonful every half hour.

After the paroxysm has been suspended by the above combination, the tendency to a recurrence of the attacks is obviated by the steady and continued use of *potassii bromidum*, in moderate doses. *Emetics* are often useful in suspending an attack, especially if it be due to indigestion.

*Locally*, the *hot*, alternating with the *cold pack*, should be constantly applied to the throat.

## DISEASES OF THE BRONCHIAL TUBES.

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### ACUTE BRONCHITIS.

**Synonyms.** Bronchial catarrh; acute bronchial catarrh; “cold on the chest.”

**Definition.** An acute catarrhal inflammation of the bronchial tubes of the larger, middle and third size; characterized by fever, sub-sternal pain, a feeling of thoracic constriction, oppression in breathing, and at first scanty, followed by more or less profuse expectoration.

**Causes.** Most frequent in childhood, especially during the period of dentition, when there exists a strong tendency to catarrh of the mucous membrane in general and of the bronchi in particular. In old age the predisposition again returns. Inhalations of irritants such as dust, smoke and air too hot or too cold. More common in climates characterized by considerable moisture of the atmosphere com-

bined with a low temperature, and especially where there are sudden and marked variations.

**Pathological Anatomy.** *Hyperæmia* of the mucous membrane of the bronchial tubes, manifested by a diffused redness, swelling, œdema and diminished secretion ; this is followed by an increased secretion and overgrowth and desquamation of the epithelial cells, together with a copious generation of young cells, the expectoration then becoming of a yellowish color. As a result of the hyperæmia, rupture of the capillaries of the mucous membrane frequently occurs, when the slight expectoration of the first stage is streaked with blood.

In cases of bronchitis following the exanthemata, or in scrofulous patients, the bronchial glands participate in the inflammation, they becoming hyperæmic, swollen and filled with secretion, and not unfrequently the glandular elements undergo a hyperplasia, and finally the "cheesy" degeneration.

**Symptoms.** The *invasion* is usually characterized by the occurrence of either nasal or laryngeal catarrh, or both, the patient feeling chilly, followed by *flushes of heat*, the limbs, joints, and even the body, are affected with *pain* of an aching, contused character, and with a sense of fatigue and want of energy ; there may be a furred tongue, anorexia and constipation.

In nervous, irritable persons, and in children, there may be slight delirium, and often in very young children, especially during the period of dentition, convulsions may usher in an attack.

After a day or two of these initiatory symptoms, those characteristic of bronchial catarrh develop.

*Pain* is experienced beneath the sternum, especially toward its upper part, of a raw, burning or tearing character, aggravated by a deep inspiration or by coughing ; the pain also radiates toward the sides, following the course of the primary bronchial tubes. *Tenderness* over the sternum is often experienced.

*Cough* from the onset, at first in paroxysms of a hard, dry character, changing as the disease progresses, and becoming looser, followed by free expectoration. The expectoration at first is small in quantity, almost transparent, frothy, and having a salty taste, often streaked with blood. As the disease progresses it becomes more abundant, of a yellowish or a greenish-yellow color, and of a tenacious consistency.

There are present *slight fever*, hot, dry skin, frequent *pulse*, loss of *appetite*, moderate *thirst* and *constipation*.

A feeling of languor and weariness, and often considerable depression, quite out of proportion to the febrile state, are not infrequent.

**Percussion.** *Normal*, except in those rare cases in which the bronchial glands are involved, when irregular spots of dullness can be developed.

**Auscultation.** *First Stage*: The bronchial membrane being swollen and dry, the respiratory murmur is *harsh* or *vesiculo-bronchial* in character, associated with diffused *sonorous* and *sibilant râles*.

*Second stage*: The secretion from the bronchial mucous membrane being increased, the respiratory murmur is *less harsh* in character, but is associated with *large and small moist or bubbling râles*.

**Diagnosis.** The points of resemblance and difference between acute bronchitis and other diseases of the chest will be pointed out when those affections are described.

**Prognosis.** Acute bronchitis of the larger tubes usually terminates in complete resolution within two weeks. In children and in the aged, the course is more protracted, and the symptoms more severe, but recovery is the rule.

**Treatment.** During the *invasion*, *quininæ sulphas*, gr. x, combined with *morphinæ sulph.*, gr.  $\frac{1}{6}$ , will usually prevent or abort an attack of acute bronchitis.

In the *first stage*, in adults, when the mucous membrane is swollen and dry, either of the following prescriptions will give prompt relief:—

R. Antimonii et potassii tart., . . . . .	gr. ij	
Liquor. ammonii acetatis, . . . . .	f $\frac{3}{3}$ iv	
Spts. ætheris nitrosci, . . . . .	f $\frac{3}{3}$ j	
(Tinct. aconiti, if indicated), . . . . .	f $\frac{3}{3}$ ss	
Syr. simplicis, . . . . ad . . . . .	f $\frac{3}{3}$ vj.	M.

SIG.—One teaspoonful every two or three hours.

Or—

R. Vini ipecacuanhæ, . . . . .	f $\frac{3}{3}$ ij	
Liq. potassii citrat., . . . . .	f $\frac{3}{3}$ v	
Syr. acaciæ, . . . . .	f $\frac{3}{3}$ j.	M.

SIG.—Tablespoonful every two or three hours.

If the cough of the dry stage be severe, or if looseness of the bowels follow the use of either of the above combinations, *tinctura opii camphorata* may be added with advantage.

For young children, the above in proportionately reduced doses, or the following :—

R. Pulv. ipecac et opii, . . . . . gr. x  
 Pulv. scillæ, . . . . . gr. xij  
 Hydrargyri chlor. mite, . . . . . gr. iv  
 Sacch. lact., . . . . . gr. x.  
 Ft. et chart. No. xij.

SIG.—One every two hours.

*Locally*: Hot mustard foot bath, and *sinapis* or *terebinthina stupes* over the chest, the patient being confined to an apartment in which the air is moistened by the vapor of hot water.

*Second Stage*: The secretion of the bronchial mucous membrane being copious, marked benefit follows the use of the following combination of Prof. H. C. Wood :—

R. Ammonii chloridi,  
 Ext. glycyrrhizæ, . . . . . ää . . . . . 3 iss  
 Glycerinin, . . . . . f3 ss  
 Mucil. acaciæ, . . . . . f3 ij  
 Syrupi simplicis,  
 Aquæ, . . . . . ää . . . . ad . . . . . f3 iiij. M.

SIG.—Dessertspoonful every two hours.

Attacks showing a tendency to linger are greatly benefited by the following :—

R. Terpine hydrate, . . . . . gr. xlviij  
 Glycerinæ, . . . . . q.s. sol.  
 Syr. lactucarii, . . . . . ad . . . . . f3 ij. M.

SIG.—Teaspoonful every hour or two.

During the attack, attention must be given to the secretions and the diet of the patient.

## CAPILLARY BRONCHITIS.

**Synonyms.** Broncho-pneumonia; "suffocative catarrh."

**Definition.** An acute catarrhal inflammation of the *terminal* bronchial tubes, or bronchioles; characterized by fever, impeded and increased respiration, impeded circulation, slight cough and scanty expectoration.

**Causes.** Most common in childhood, following exposure to cold

or sudden changes of temperature; associated with measles and whooping cough.

**Pathological Anatomy.** *Hyperæmia*, redness and swelling of the lining membrane of the bronchioles, with the exudation of a tough, tenacious secretion.

The air vesicles may remain unaffected, but in the majority of cases they are involved, producing the complication known as "*catarrhal pneumonia*."

In those cases in which the air cells are not involved in the inflammatory changes, the air passes, during the act of inspiration, through the secretion blocking the smaller tubes, but is prevented from escaping during the act of expiration, the secretion in the smaller tubes acting as a valve; the result is distention of numerous vesicles, producing a circumscribed or diffused *functional emphysema*. If the secretion produces complete closure of any of the smaller tubes, the air previously drawn into the vesicles will be absorbed, causing *collapse* (*atelectasis*).

If the inflammation extends to the alveoli of the lungs, it produces the condition known as *broncho-pneumonia*, a frequent complication in children and feeble elderly people; it is most commonly lobular in character, whence the term "*lobular pneumonia*."

**Symptoms.** Usually preceded by more or less ordinary bronchitis, followed by *rise of temperature*,  $102\text{--}103^{\circ}$  F., *difficult and increased respiration*, with *paroxysms* in which the dyspnœa is markedly aggravated, when *cyanosis* rapidly develops.

The circulation through the lungs is impeded by the dyspnœa, the *pulse* becomes feeble and flickering, and there results general congestion of the venous system, the *countenance livid*, the *lips and nails blue*, the *surface cold*, and often covered by a *clammy perspiration*, the *mind dull*, and in children stupor and convulsions rapidly supervene, the result of the *non-aeration of the blood*. The *cough* is slight, but of a *suppressed character*, the *expectoration scanty*. When *cyanosis* occurs the *cough* may almost entirely cease; expectoration also ceases, death soon following, from *apnoea* and *depression*.

**Percussion.** *Normal*, except over those portions of the lungs which are in a condition of *collapse*, when dullness rapidly develops and may as rapidly disappear, changing to other portions of the lung.

**Auscultation.** *First stage, harsh or vesiculo-bronchial, soon*

followed by diminished respiratory murmur, associated with *subcrepitant râles*.

**Diagnosis.** Capillary bronchitis is often mistaken for true catarrhal pneumonia, the points of distinction between which will be pointed out when discussing that affection.

**Prognosis.** In children, on account of their inability to expectorate, which tends to rapid collapse of the lungs, and in the aged, the prognosis is most grave. In the strong and vigorous recovery follows prompt and energetic treatment.

**Treatment.** From the very onset of the attack the treatment must be supporting, with the addition of such measures as seem to possess a controlling influence over the catarrhal process.

The patient must be confined to bed, well covered and the temperature varying between  $75^{\circ}$  and  $80^{\circ}$ , the air moistened with steam. In the first stage *dry cups*, mild *sinapis* applications or *terebinthina stipes* should be applied to the chest, after which it should be covered with an oil-silk jacket or the jacket poultice, if the child be not too young to permit so heavy an application without adding to the distress in the breathing.

The diet must be of the most nutritious character, the great aim being to sustain the powers of life until the catarrhal process has passed through its different stages, hence milk, eggs, chicken, mutton and beef broths, with the free use of *stimulants*, commenced early and in amounts large enough to overcome the signs of depression which are present early in the attack.

If the *fever* be high, over  $102^{\circ}$  F., *quininæ sulphas* is indicated in full doses, for a child; either in suppository or the following:—

R.	Quininæ sulphatis, . . . . .	3j	
	Acid. sulphurici dilut., . . . . .	q. s.	
	Spts. ætheris nitrosi, . . . . .	f 3 iv	
	Syr. tolu., . . . . .	f 3 iv	
	Aquaë menth. p., . . . . .	f 3 j.	M.

SIG.—One teaspoonful every two or three hours.

Or—

R.	Antipyrine, . . . . .	gr. xxxij	
	Sacch. alb., . . . . .	f 3 j	
	Aq. menth. p., . . . . .	3j	
	Elix. simplicis, . . . . ad	3 ij.	M.

SIG.—One teaspoonful every hour or two till four or five doses.

For the *catarrhal* process either of the following, regulating the dose in accordance with the age of the patient :—

R.	Syr. ipecac, . . . . .	m <sub>v</sub> -xx
	Spts. ætheris nitrosi, . . . . .	m <sub>v</sub> -xv
	Tinct. opii camph., . . . . .	m <sub>v</sub> -xx
	Tinct. scillæ, . . . . .	m <sub>v</sub> -xx
	Liq. potassii citrat, . . . . .	m <sub>xl</sub> -3 ij. M.

SIG.—Every two hours.

Or—

R.	Potassii iodidi, . . . . .	gr. ij-v
	Ammonii carbonat, . . . . .	gr. ijj-v
	Syr. glycyrrh, . . . . .	f 3 ss
	Syr. tolu, . . . . .	f 3 ss. M.

SIG.—Every two or three hours.

If *suffocation* is imminent the use of *emetics* are indicated ; the most suitable are *ipecacuanha* or *hydrargyri sulphas flava*, care being taken not to repeat emesis so often as to produce exhaustion. Prof. H. C. Wood, in desperate cases of suffocative catarrh, advises the alternate use of the hot and cold douche conjointly with stimulating remedies.

### CROUPOUS BRONCHITIS.

**Synonyms.** Membranous bronchitis ; plastic bronchitis ; diphtheritic bronchitis.

**Definition.** An acute inflammation of the mucous membrane of the larger and middle-sized bronchial tubes, attended with an exudation, forming a membraniform layer, which is closely adherent to the mucous surface ; characterized by febrile reaction, cough, difficult breathing, scanty expectoration, followed by the expulsion of the false membrane in the form of patches or casts.

**Causes.** Associated with membranous laryngitis from extension downward ; asthma ; emphysema ; phthisis ; but most commonly the result of exposure to cold and damp, in those of strong and vigorous constitutions.

**Pathological Anatomy.** *Hyperæmia* of the mucous membrane of the bronchial tubes, associated with *swelling* and *œdema*, during which the surface is covered with a whitish or grayish-white, firmly adherent, *membranous deposit*, cemented together by a coagulable exudation, and prolonged by rootlets from its under surface

into the bronchial follicles, which sooner or later is loosened and detached by suppurative process and is expectorated after a violent fit of coughing or vomiting. When expectorated, the *false membrane*, as it has been termed, has either the form of patches or is thrown off entire from the bronchial tube, and may be found to consist of casts representing more or less of the bronchial subdivisions, and presenting an appearance not unlike "boiled macaroni."

On microscopical examination, the detached membrane presents fibrillæ which characterize fibrine or lymph in other situations, and if placed in a solution of acetic acid, it becomes greatly swollen, while ordinary mucus contracts and becomes more dense if added to the same solution.

**Symptoms.** There are no symptoms or signs by means of which this variety of bronchitis can be distinguished from ordinary catarrhal bronchitis, *prior to the expectoration of the false membrane*.

*Expectoration* is preceded and accompanied by *violent paroxysms of coughing*, and after more or less of the membrane has been raised a muco-purulent expectoration, streaked with blood, may be present for several days.

**Duration.** The inflammation may be either *acute, sub-acute* or *chronic*, expectoration of patches or strips of the membrane being repeated at intervals of days, weeks, months, or even years.

**Prognosis.** In adults, favorable, if not associated with other grave affections, such as phthisis, pneumonia or emphysema. In young children it may cause obstruction to the respiration, and not unfrequently proves fatal.

**Treatment.** As the character of the inflammation can seldom be determined until the membrane or portions of it have been expectorated, the treatment is at first the same as in cases of ordinary acute bronchitis.

As soon, however, as the character of the inflammation can be determined, active *emesis* is the most effective means of removing the obstruction caused by the false membrane, the best agents of this class being either *hydrargyri sulphas flava*, *ipecacuanha*, or *zinci sulphas*, to be repeated as indicated.

*Inhalations* of the vapor of water, and especially of *lime water*, are highly serviceable.

To prevent the formation of membrane, Prof. Bartholow strongly urges the use of *ammonii iodidum* and *carbonas* combined, in small

doses every hour or two. In a case treated by the author after this method, excellent results followed.

In cases showing a tendency to become chronic, good results will follow the application of flying *blisters* to the chest and the internal administration of *arsenicum* and some preparation of *pix liquida*.

### CHRONIC BRONCHITIS.

**Synonyms.** Chronic bronchial catarrh ; winter cough ; secondary bronchitis.

**Definition.** A chronic inflammation of the mucous membrane of the larger and middle-sized bronchial tubes ; characterized by cough and more or less profuse expectoration, plus, in many cases, the symptoms of *emphysema* of the lungs, which complicates the majority of cases.

Chronic bronchitis may be either *primary* or *secondary*.

**Causes.** *Primary*, the exposure to wet or cold, or the repeated inhalation of dust, vapors, or other irritants. *Secondary*, due to gout, rheumatism, syphilis, cardiac, renal or pulmonary diseases, or alcoholism.

**Varieties.** I. *Mucous catarrh*, associated with moderate expectoration. II. *Bronchorrhœa*, profuse expectoration. III. *Dry catarrh*, scanty expectoration. IV. *Fetid bronchitis*.

**Pathological Anatomy.** The mucous membrane of the bronchial tube is discolored, being of a more or less dull red, often of a deeply venous hue, mingled with a grayish or brownish color. These changes may be either in patches or extensively diffused. The vessels of the membrane are dilated. The mucous membrane is thickened, resulting in the reduction in the calibre of the tube and a roughening of its internal surface. The submucous tissue becomes infiltrated, contracted and indurated.

The elastic and muscular coats of the tubes become hypertrophied, lose their elasticity, and the cartilages become the seat of calcareous deposits.

As the result of the loss of elasticity and muscular tone of the tubes they become irregularly dilated, "*bronchial dilatation*." The dilatations may be uniform in character, resembling somewhat the fingers of a glove, or they may be *sacculated* or *globular*, forming actual cavities in the bronchial structure.

In the *mucous variety* the secretion consists of young cells and mucous corpuscles, having a yellowish color; in the *dry variety*, the "catarrh sec" of Lænnec, or "dry bronchial irritation," the secretion is scanty, tough, semi-transparent, and occurs in defined globular masses; in *bronchorrhœa*, which is usually associated with bronchial dilatation, the secretion is abundant, greenish yellow in color, and often fetid.

**Symptoms.** The most characteristic symptoms of chronic bronchitis are the *cough* and *expectoration*. Unless associated with other diseases, the general health suffers but little, if at all, constitutional symptoms being present only during acute exacerbations.

*Mucous catarrh*, or, from its occurring most commonly during the winter months, "winter cough," is characterized by paroxysms of cough, more or less violent, followed by the expectoration of a yellowish mucus.

*Dry catarrh* is characterized by a harsh cough, a feeling of soreness or rawness under the sternum, and the expectoration of *small globular masses*; this variety occurs with emphysema, gout, rheumatism and asthma.

*Bronchorrhœa*, which is associated with *bronchial dilatation*, and most common in the elderly, is characterized by paroxysms of severe coughing, followed by the copious expectoration of greenish-yellow, often fetid, mucus; the amount expectorated often amounts to four or five pints in the twenty-four hours.

*Fetid bronchitis*, often associated with bronchial dilatation, has an excessively fetid odor of the breath and expectoration. The decomposition of the secretion may cause gangrene of the bronchial mucous membrane, and even of the lung structure.

**Percussion.** Unless complicated with other affections, *normal*; if bronchial dilatation occur, there are *diffused* spots of the *tympanitic* or *amphoric* percussion sound, the physical condition being a circumscribed cavity containing air and connecting with a bronchial tube.

**Auscultation.** *Harsh* or *vesiculo-bronchial* respiration, associated with more or less profuse, *sonorous*, *sibilant*, and *large* and *small bubbling râles*; in *bronchial dilatation*, in addition to the harsh respiration, is found *broncho-cavernous breathing*, with large and small *gurgling râles*.

If *emphysema* complicate chronic bronchitis, the physical signs are

somewhat modified, and will be pointed out when discussing that affection.

**Prognosis.** If unassociated with disease of the lungs or heart, chronic bronchitis is never dangerous to life, although the symptoms are present more or less continually, and aggravated upon the least exposure.

If associated with phthisis, emphysema, disease of the heart, or of the kidney, the prognosis is governed by those affections.

**Treatment.** Cases of chronic bronchitis, of whatever variety, should observe the following general rules: 1. Attention to the general health. 2. The clothing; wearing flannel the year round, or, what is better, silk under-clothing, taking care that the opposite extreme of too much clothing be not practiced.

The medical treatment is guided by the *cause, character and severity* of the disease.

If *secondary* to other affections, in the majority of cases remedies directed to the bronchial mucous membrane are *contra-indicated*. If the result of the rheumatic or gouty diathesis, in addition to the remedies directed to the disease itself, should be combined change to a warm climate, if possible, and a more or less protracted course of *potassii iodidum*, or *lithii citras*, or a residence at one of the *alkaline springs*.

For mucous catarrh, with acute exacerbations:—

R.	Ammonii chloridi,	ij	$\frac{3}{2}$	ij	
	Glycerini,	iss	$\frac{3}{2}$	iss	
	Codeinæ sulph.,	gr. $\frac{1}{2}$			
	Vini picis,	ijj	$\frac{3}{2}$	ijj	
	Syr. prun. virg.,	iss.	$\frac{3}{2}$	iss.	M.

SIG.—Tablespoonful every three or four hours.

*Dry catarrh* is greatly benefited by—

R.	Potassii iodidi,	gr. v-x		
	Elix. cinchonæ,	xx	$\frac{3}{2}$	
	Vini picis, liq.	ad	$\frac{3}{2}$	j.

Three times a day.

Or—

R.	Ext. eucalypt. fld.,	ij	$\frac{3}{2}$	j.
	Ammonii chloridi,	ij	$\frac{3}{2}$	ij.
	Ext. glycyrrhizæ,	ij	$\frac{3}{2}$	ij.
	Syr. tolu,	ijj.	$\frac{3}{2}$	ijj.

SIG.—One teaspoonful every three or four hours.

For *bronchorrhœa*, *copaiba*, gtt. v-x every three hours, or *spts. terebinthinae*, gtt. v, every four hours, or *acidum carbolicum*, gr. ss, four times a day, and at the same time using, *ol. morrhuae* and *arsenicum*, or, if these means fail, inhalations of *alumen*, *acidum gallicum* or *acidum tannicum*.

If the *expectoration* be *fetid*, "fetid bronchitis," Prof. DaCosta recommends the internal use of *acidum carbolicum*, gtt. j every third hour, with *inhalations* of *acidum carbolicum* (gr. v, *aqua*,  $\frac{3}{2}$ j) two or three times a day.

*Locally*, irritation with *tinctura iodi*, or flying blisters, repeated once or twice weekly, is of advantage.

## ASTHMA.

**Synonyms.** Nervous asthma; bronchial asthma.

**Definition.** A paroxysmal spasmodic contraction of the muscular layer surrounding the bronchial tubes, and perhaps associated with a tonic spasm of the diaphragm, and more or less bronchial catarrh; characterized by spasmodic attacks of great dyspnœa, continuing usually for several hours.

**Causes.** A true neurosis of the respiratory apparatus.

The result of peripheral or local disturbances in the nervous system, often hereditary; pressure on the pneumogastric nerve; cardiac disease; gastric catarrh and constipation, resulting in irritation of the end organs of the pneumogastric; uterine, hepatic, or nephritic disease; inhalation of various substances, as ipecac, turpentine, or irritating dusts; climate; mental and moral influences.

Asthma is more common in men than in women; in childhood and young adults than those of middle life and old age; in the well-to-do and wealthy than in the poor.

**Symptoms.** The onset of a *first attack* of asthma is *abrupt* and *sudden*, the succeeding attacks being preceded by *prodromes*, which the individual rapidly learns to appreciate, to wit: *coryza*, *bronchial irritation*, *thoracic constriction*, marked *dyspepsia*, or a large passage of pale, limpid urine, the "hysterical urine."

The *paroxysm* begins, in the majority of cases, in the *early morning hours* or during the *afternoon*, with a *feeling of anguish* and *constriction in the chest* and an *intense desire for air*. The breathing is accompanied with *loud wheezing*, the *face is flushed*, at times even

cyanosed, and bathed in perspiration, the eyes stare, the eyeballs protrude, and the muscles of the neck become prominent as they aid in the effort for air. The dyspnæa soon becomes so severe that the inspiration is but a gasp, the lips are pallid, cyanosis deepens, and the patient feels as if death were impending.

After some minutes or hours the respiration becomes easier, more air enters the lungs, the cyanosis disappears, and gradually the paroxysm ceases, the patient feeling exhausted and the chest fatigued.

During the paroxysm there is a short dry cough, becoming looser as the attack subsides, the expectoration either consisting of white pellets of mucus, at times streaked with blood or profuse watery mucus.

The duration of an attack varies from three to ten hours. Instead of single paroxysms, slight remissions may occur at intervals of one, two or three hours, to be followed by exacerbations lasting from four to six hours, continuing for a week or two, preventing the patient lying down or taking food.

**Percussion.** During the paroxysm, hyper-resonance over both lungs, termed *vesiculo-tympanitic*, the "bandbox tone" of Bamberger.

**Auscultation.** First stage feeble or absent vesicular murmur, with prolonged expiration associated with loud wheezing, whistling, sibilant and sonorous râles; as the paroxysm subsides the vesicular breathing becomes more apparent and is associated with moist râles.

**Prognosis.** In itself asthma is not fatal to life; but if the paroxysms are frequently repeated there results either emphysema, cardiac dilatation, with subsequent dropsy, or even cerebral hemorrhage.

Attacks of asthma frequently occur as a complication in emphysema, chronic bronchitis and valvular diseases of the heart.

**Treatment.** There are two indications, to wit: the relief of the paroxysm, and to prevent its recurrence.

To relieve the paroxysm, no medication is so effective as the hypodermic injection of morphinæ sulph., gr.  $\frac{1}{6}$  to  $\frac{1}{4}$ , combined with atropinæ sulph., gr.  $\frac{1}{25}$ . Chloral, gr. x, repeated, where no heart complication exists, is often effective; drinking strong, hot black coffee is often serviceable; chloroformum, æther or amyl nitris inhalations have been recommended; also nauseant expectorants, to wit: lobelia, ipecac, scilla, or ext. grindelieæ fld., gtt. xx, repeated every two or three hours.

Dr. Pepper speaks highly of the following for the paroxysm:—

R.	Ammonii bromidi, . . . . .	$\frac{3}{2}$ ij	$\frac{3}{2}$ ij
	Ammonii muriat., . . . . .	$\frac{3}{2}$ iss	$\frac{3}{2}$ iss
	Tinct. lobeliae, . . . . .	f $\frac{3}{2}$ iij	f $\frac{3}{2}$ iij
	Spts. ætheris comp., . . . . .	f $\frac{3}{2}$ j	f $\frac{3}{2}$ j
	Syr. acaciæ q. s., . . . . .	f $\frac{3}{2}$ iv.	M.

SIG.—Dessertspoonful in water every hour or two.

A combination that often affords decided relief is—

R.	Chloral, . . . . .	$\frac{3}{2}$ viij	$\frac{3}{2}$ viij
	Ammonii chloridi, . . . . .	$\frac{3}{2}$ iiij	$\frac{3}{2}$ iiij
	Morphinæ muriat., . . . . .	gr. iij	gr. iij
	Antimonii et potassii tartras, . . . . .	gr. iiss	gr. iiss
	Ext. grindelæ robust. fluid., . . . . .	f $\frac{3}{2}$ j	f $\frac{3}{2}$ j
	Ext. glycyrrh., . . . . .	$\frac{3}{2}$ ij	$\frac{3}{2}$ ij
	Syr. aurantii cort., . . . . ad . . . .	$\frac{3}{2}$ iv.	M.

SIG.—One teaspoonful in sweetened water every three or four hours.  
(Davis.)

Another remedy that at times is successful is *syrupus hydriodic. acidum*, M<sub>xv</sub>—xxx every three or four hours.

Inhalations of the fumes of belladonna, stramonium, nitre-paper, chloroform, ethyl bromidum, or the use of various pastilles or cigarettes, are of immense benefit in many cases. A twenty per cent. solution of *menthol* as an inhalation has been successful in some cases.

Paroxysms of asthma are said to be relieved by *rectal injections* of *sulphureted hydrogen* after the manner suggested by Bergeon of Paris.

If an attack is *impending* it may often be aborted by drinking freely of strong *black coffee*, or by full doses of the *bromides*.

To prevent recurrence of the *paroxysms*, the general health must be strictly watched, any of the complications or causes of the attack attended to, systematic exercise, bathing, regulated diet, and change of climate when possible.

Internally, good results are sometimes attained by a long course of *belladonna*, *arsenicum* or *potassii iodidum*.

### HAY ASTHMA.

**Synonyms.** Hay fever; autumnal catarrh; rose fever.

**Definition.** An acute catarrhal inflammation of the upper air passages, extending to the bronchial tubes, associated with spasmodic

contraction of their muscular layer; characterized by coryza, croupy or wheezy cough and difficult respiration.

**Causes.** An affection of the nervous system; often hereditary.

Persons in whom the predisposition exists have attacks excited by the inhalation of the pollen of grasses, rye, corn, wheat or roses.

**Pathological Anatomy.** Hypertrophy of the inferior and middle turbinated bones; a peculiar hyperæsthesia of the mucous membrane covering the inferior and middle turbinated bones, the middle meatus, the floor of the nose and that part of the septum below the limit of the olfactory membrane are frequently associated with the disease.

**Symptoms.** Begins by severe *coryza*, with *sneezing*, a clear, watery, *nasal discharge*, congested eyes and Eustachian tubes, rapidly extending to the *larynx* and *bronchial tubes*, when occur a *hoarse*, *croupy* and *wheezing cough*, and *difficulty of breathing*. The dyspnœa occurs in paroxysms, which are often as severe as those occurring during a regular asthmatic attack.

The paroxysms remit after a few days, returning again for several days or weeks, and again remitting, the bronchial catarrh persisting for a month or more.

The constitutional symptoms are mild, unless complications occur.

**Complications.** The affection may extend to the finer bronchial tubes (capillary bronchitis); congestion or *œdema* of the lungs and pneumonia are not infrequent.

**Duration.** Unless a change of climate is resorted to, paroxysms of hay fever continue more or less severe for six, eight or ten weeks of the year; each year the paroxysms growing more severe.

**Prognosis.** The affection never proves fatal in itself, but one or more of the following *sequelæ* may result, to wit: Asthma, chronic bronchitis, or loss of the special sense of hearing or of smelling.

**Treatment.** No specific, unless the hypertrophy of the turbinated bones be a constant phenomena, when their removal by the galvano-cautery would at once produce a cure.

An attack of hay asthma is often prevented by a *change of climate* during the season of the year when the attacks are most common, to wit: the *early autumn*. Any of the following locations may be selected, White Mountains, Catskills, Adirondacks, Rocky Mountains, or a sea voyage.

Attacks are sometimes aborted and always *relieved* by the appli-

cation to the nares of tablets of *cocaine hydrochlorate*, gr.  $\frac{1}{6}$  every hour.

Success has followed the use of *quinina*, gr. v, three times a day, beginning one month before the expected paroxysm. After the attack has fairly begun, *potassii iodidum*, gr. xv, three times a day, seems to modify somewhat the severity of the paroxysms; or the following powder, by *insufflation* :—

R.	Bismuth. subnit., . . . . .	3 ij	
	Acid. tannic., . . . . .	3 j	
	Iodoformi, . . . . .	gr. xv.	M.

SIG.—Every three or four hours.

Prof. Bartholow "has seen several cases benefited greatly" by a solution of *quinina* applied to the nares, as suggested by Helmholtz; "but to achieve success the application must be thorough and timely."

The following applied thoroughly to the nostrils has a high repute:—

R.	Menthol, . . . . .	3 j	
	Cerat. simpl., . . . . .	3 ij	
	Ol. amygd. dulcis, . . . . .	3 iss	
	Zinci oxidii purae, . . . . .	3 j	
	Acid. carbolici, . . . . .	3 ss.	M.

SIG.—Apply every few hours.

Cases accompanied by a profuse watery discharge have this symptom at least modified by minute doses of *atropinæ sulphas*, with *morphinæ sulphas*, every three or four hours.

A long course of *arsenicum* in minute doses sometimes removes the susceptibility to the disease.

## WHOOPING COUGH.

**Synonyms.** Hooping cough; pertussis.

**Definition.** A convulsive, paroxysmal cough, consisting of a number of forcible expirations, followed by a series of deep, loud, sonorous inspirations (the whoop), repeated several times during each paroxysm, and associated with catarrh of the bronchial tubes.

**Causes.** Chiefly a disease of childhood, one attack generally removing the susceptibility; contagious; the result of an unknown poison, perhaps atmospheric, affecting the nervous system.

**Pathology.** The changes, if any, occurring in the nervous sys-

tem are unknown. It is said that "irritation of the internal branch of the superior laryngeal nerve produces relaxation of the diaphragm, spasm of the glottis and a convulsive expiration, the series of phenomena present in a paroxysm of asthma."

*Hyperæmia* of the mucous membrane of the nares, pharynx, larynx and bronchial tubes, with diminished *secretion*, followed by an increased secretion of a transparent mucus, afterward becoming purulent, the mucous membrane pale and anaemic.

**Symptoms.** Divided into three stages, to wit: *catarrhal*, *spasmodic* and *terminal*.

*Catarrhal stage* originates as an ordinary naso-laryngo-bronchial catarrh with a loose cough. *Duration* one or two weeks.

*Spasmodic stage*: The cough becomes *paroxysmal*, consisting of a succession of *short, rapid, expiratory* efforts, the face becoming red, the eyes swollen and protruding, the body bending forward, and when these expiratory efforts have exhausted the breath, they are followed by a *deep, loud, crowing inspiration*—the *whoop*. Each paroxysm being composed of three such spells, the last one followed by the *expectoration* of a small amount of *tough, viscid mucus*.

The attacks of *cough* may be so severe as to cause *vomiting*, and if the vomiting occur shortly after food has been taken, the nutrition of the patient will suffer. Profuse *epistaxis* is not infrequent. *Duration* about four weeks.

*Terminal stage.* The paroxysms recur at longer intervals, are of shorter duration and less intensity, the catarrhal symptoms being more marked, the expectoration freer. *Duration*, one or two weeks, often followed by the "cough of habit."

**Complications.** Congestion of the lungs, capillary bronchitis, pneumonia and emphysema, or, rarely, convulsions, hydrocephalus, or apoplexy.

**Diagnosis.** During the catarrhal stage, whooping cough cannot be distinguished from a common cold, but on the advent of the characteristic whoop the diagnosis is evident.

**Prognosis.** Depends upon the age and strength of the patient, the severity of the paroxysms, and the presence or absence of complications. Ordinary cases, favorable. Moderately severe attacks during infancy are followed by cerebral symptoms, while attacks occurring in adults are followed by chest symptoms.

**Treatment.** No specific. A self-limited disease. Remedies

will not cure the disease, but often modify the severity of the symptoms.

Prof. Da Costa prefers *quininæ sulphas*, in full doses, or *chloral* in good-sized doses, often advantageously combined with the *bromides*, and the use of a spray of *sodii bromidum* (gr. xx, and aquæ, fʒj) to which may be added *extractum belladonnæ fluidum*, mlij. A remedy of great utility is *ammonii bromidum*. I have seen excellent results from *antipyrine* in doses of gr. j-iij every three hours; if added to some expectorant mixture it seemed to act better. The paroxysms are lessened in severity by the following :—

R.	Codeinæ sulph., . . . . .	gr. j
	Acid. carbolic., . . . . .	m viii
	Syr. simplicis, . . . . .	fʒ ss
	Glycerini, . . . . .	fʒ j
	Syr. limonis, . . . . .	fʒ ss. M.

SIG.—One teaspoonful every two or three hours.

*Belladonna* may be added to any of the remedies named with advantage.

The use of *cocaine* lozenges modifies the paroxysms in some cases.

Dr. Keating reports "remarkable improvement in four cases of whooping cough by the use, four or six times daily, of a spray composed of"—

R.	Ammonii bromid.,	
	Potassii bromid., . . . . .	aa . . . . . ʒj
	Tinct. belladonnæ, . . . . .	fʒ j
	Glycerini, . . . . .	fʒ j
	Aquæ rosæ, . . . . . q. s. ad . . . . .	fʒ iv.

The diet of the patient must be regulated, the clothing to be warm but not too heavy, and the patient kept in the open air as long as possible.

### EMPHYSEMA.

**Synonym.** Vesicular emphysema.

**Definition.** Dilatation of, or increase in the size and capacity of, the air vesicles, characterized by enlargement of the chest, difficulty of breathing, especially on exertion, and associated sooner or later with dilatation of the heart.

**Causes.** The *predisposing* cause of emphysema is a hereditary

nutritive derangement of the lung structure, often associated with a rigid enlargement of the thorax.

The *exciting cause* is the result either of a *too forcible* and long continued inspiration—*the theory of inspiration*—or the *excessive mechanical distention* of the vesicular walls by forced expiration—*the theory of expiration*.

What is known as *vicarious emphysema* is a distention of the air cells of the healthy portion of the lung, some other part being the seat of consolidation.

*Interlobular emphysema* is the presence of air in the spaces between the lobules of the lungs underneath the pulmonary pleura.

**Pathological Anatomy.** The situation of vesicular emphysema is, in the majority of cases, the *superior portions* of the chest, and is more marked on the *left side* than on the right.

An emphysematous lung feels remarkably soft to the touch, and upon cutting, a dull, creaking sound is barely perceptible. It is of a pale red color, the vesicular walls are thinner and slighter, the vesicles are greatly enlarged, sometimes to the size of a pea or bean, and have an irregular shape, and traversing most of these large cysts (dilated vesicles) a few delicate bands, the remains of the lacerated interalveolar septa, are visible. With the destruction of the septa many of the capillaries are destroyed, whereby the emphysematous tissue is remarkably bloodless and dry.

In consequence of the destruction of so many of the capillaries, the obstruction to the pulmonary circulation becomes so great that the pulmonary artery and right cavities of the heart are greatly distended; finally, the muscular tissue of the heart undergoes granular, followed by fatty degeneration. The distention of the veins results in a general venous stasis, to wit: nutmeg liver, congested kidneys, and gastro-intestinal catarrh.

**Symptoms.** The chief symptoms of vesicular emphysema are *difficulty of breathing*, greatly aggravated on exertion, more or less *cough*, the result of an attending bronchitis, and the various symptoms resulting from *dilatation of the heart*. The distress of the patient is often increased by paroxysms of asthma.

**Inspection.** The shoulders are rounded, the intercostal spaces widened, the vertical diameter elongated, with circumscribed prominences between the clavicles and nipples, often increased by the

act of coughing—the peculiar “barrel-shaped” chest characteristic of this disease.

The character of the respiratory movements is marked, there being but slight movement observed on forcible respiration, the chest having the constant appearance of a full inspiration.

**Palpation.** The vocal fremitus is diminished, and the cardiac impulse depressed and nearer to the sternum.

**Percussion.** The resonance is increased (hyper-resonant) over all the emphysematous portions, and if the whole lung be involved, extends to the seventh or eighth rib anteriorly, and to the twelfth rib posteriorly. The hepatic dullness may not begin until the inferior margin of the ribs is reached; the cardiac dullness is lessened, on account of the emphysematous lung nearly covering the heart.

**Auscultation.** The vesicular murmur is weakened, and in pronounced cases almost absent. If bronchitis be present, the inspiratory sound may be rough or sibilant in character, but its duration is always shortened. *Expiration is always prolonged*, and if bronchitis be present, may be associated with more or less pronounced moist or bubbling râles.

The first sound of the heart is lessened in intensity and duration, the second sound being sharply accentuated.

**Diagnosis.** Bronchitis is distinguished from emphysema by the absence of dyspnœa, hyper-resonance of the chest, changes in its shape, size and movements, and the disturbance of the circulation.

*Spasmodic asthma* by the paroxysmal character of the affection, emphysema being a permanent malady, with attacks of asthma.

*Cardiac diseases* due to other causes than emphysema do not have the characteristic physical signs of that affection.

**Prognosis.** Vesicular emphysema is essentially a chronic disease. In itself it rarely proves fatal, but if aggravated, from any cause, or if associated with frequent or prolonged asthmatic paroxysms the cardiac changes are hastened, general dropsy supervenes, death occurring from exhaustion, or, more commonly, as the result of intercurrent attacks of pneumonia.

**Treatment.** It being impossible to restore the altered lung structure, the indications for treatment are to relieve the *symptoms* and to endeavor to prevent its further *progress*.

For the relief of the asthmatic paroxysms, *morphinæ sulphas* com-

bined with *atropinæ sulphas* may be used hypodermically, or *ext. quebracho fld.*, 3ss-j, every hour until relief, or large doses of *potassii bromidum*, frequently repeated.

For attacks of bronchial catarrh use—

R.	Ammonii chloridi, . . . . .	ij	
	Spts. frument., . . . . .	fij	
	Glycerini, . . . . .	fij	
	Syr. prun. virg., . . . . ad	fij	M.

SIG.—Half-tablespoonful every few hours.

To prevent the progress of the affection, remove the bronchial catarrh, relieve the difficulty of breathing, and strengthen the cardiac action, no one combination seems comparable with the following:—

R.	Potassii iodidi, . . . . .	gr. v	
	Strychninæ sulph., . . . . .	gr. $\frac{1}{40}$	
	Liq. potassii arsenit., . . . . .	m <sub>v</sub>	
	Aq. lauro-cerasi, . . . . .	fij.	M.

SIG.—Four times a day.

But of all means hitherto proposed for the relief of emphysema, nothing has approached the *inhalation of compressed air*, by means of the apparatus of Waldenberg.

The *dropsy* arising from failure of the heart to compensate for the circulatory derangement in the lungs, may be relieved for a time by the use of *digitalis*, or, if this fails, *scilla* combined with *hydragogue cathartics*.

### HÆMOPTYSIS.

**Synonyms.** Bronchial hemorrhage; broncho-pulmonary hemorrhage; bronchorrhagia.

**Definition.** The expectoration of pure or unmixed blood, usually of a bright red color, following the act of coughing.

**Causes.** In the majority of cases, the result of *tubercular* disposition in the walls of the minute bronchial arteries; excessive cardiac action; bronchial congestion; excessive bodily exertion, straining, lifting or running; a symptom of *hæmophilia* ("bleeder's disease").

**Pathological Anatomy.** Hæmoptysis rarely causes death in itself, so that few opportunities for observing post-mortem appearances are obtained, and when they do occur, the location of the hemorrhage is seldom found.

The air passages are more or less filled with clotted blood, the mucous membrane is swollen, and of a dark red color, rarely, pale and bloodless. The air cells contain blood clots, or are distended with air, the bronchi being filled with clots preventing its escape. Unless the clots are rapidly removed by expectoration or absorption, a secondary inflammation originates around about them.

**Symptoms.** "Spitting of blood" occurs suddenly; rarely, it is preceded by epistaxis, cardiac palpitation and some difficulty of breathing.

It begins with a sensation of *warmth* under the sternum, *tickling* in the throat, a *sweetish taste* in the mouth, which, upon attempting to remove by the act of coughing, a *warm, saltish, bright red, frothy liquid* gushes from the mouth and nose. The quantity of blood raised varies from an ounce to a pint. The appearance of the blood depresses the individual, he becoming *pale, tremulous, often fainting*.

The attack may subside within half an hour to several hours, returning for several days, in the meantime the expectoration being either bloody or streaked with blood.

A slight febrile reaction, with chest pains, supervenes upon the hemorrhage, the result of the inflammation at the site of the bleeding, which soon subsides, except where blood clots develop a secondary pneumonia, which may undergo the cheesy metamorphosis.

**Auscultation.** *Coarse, bubbling râles* are discerned in circumscribed portions of the chest.

**Diagnosis.** From *epistaxis*, or hemorrhage from the posterior nares, it is distinguished by the absence of air bubbles and an inspection of the fauces and the nasal cavities.

*Hæmatemesis*, or hemorrhage from the stomach, differs from *haemoptysis* in the blood being *vomited* instead of expectorated, of a *dark color, clotted*, mixed with the acid contents of the stomach, followed with black, tar-like stools, and *the absence of râles in the chest*.

Exceptions to the above occur when the blood from the lungs is first swallowed and afterwards raised by vomiting, or when the hemorrhage in the stomach is caused by the erosion of a large artery, the result of ulcer of the stomach; in these cases, however, the raising of blood is preceded by epigastric pain and the blood is not frothy.

**Prognosis.** *Hæmoptysis* in itself rarely terminates fatally, although causing much depression; the patient rapidly recovers, unless secondary pneumonia results. In nine cases out of ten it is the prognostic sign of *phthisis*.

**Treatment.** *Perfect rest in bed*, the head and shoulders elevated, and perfect quiet, the diet to be bland, the drinks cool, the patient slowly swallowing small particles of ice. *Common salt*, slowly dissolved in the mouth, is a popular remedy, and if of no real benefit, serves to occupy the attention of the patient and friends until medical advice is obtained.

The hypodermic injection of *ergotin*, gr. x-xxx, or the internal administration of *extractum ergotæ fluidum*, 3ss-j are valuable, or :—

R. Acid. gallic., . . . . .	gr. xv
Acid. sulph. dil., . . . . .	m <sub>x</sub>
Aqua cinnamon, . . . . .	3 iv. M.

Repeated every fifteen or twenty minutes.

Or *tinctura matico*, 3j, or *extractum hamamelis fld.*, m<sub>xx</sub>-3j, *alumen*, gr. xx, or *acidum gallicum*, gr. v-x, frequently repeated.

If the hemorrhage causes great nervous excitement, or depression, *opium*, either hypodermically or internally, to quiet the patient, is indicated.

*Inhalations*, by means of the steam atomizer, of either *Monsel's solution* or *tinctura ferri chloridum*, are recommended when the above means fail.

Prof. Da Costa recommends, for frequent small hemorrhages, continuing day after day, *cupri sulphas*, gr. ( $\frac{1}{2}$ ), ext. opii, (gr.  $\frac{1}{2}$ ), p. r. n.

## DISEASES OF THE LUNGS.

### CONGESTION OF THE LUNGS.

**Synonym.** Hyperæmia of the lungs.

**Definition.** An increase in, or abnormal fullness of, the capillaries of the air cells; *active* congestion when the result of an accelerated circulation; *passive* congestion when caused by an impeded outflow from the capillaries.

**Causes.** *Active.* Increased cardiac action; over exertion; alcoholic excesses; mental excitement; inhalation of cold or hot air.

*Passive.* Obstruction to the return circulation. Dilated heart; valvular diseases; low fevers (hypostatic congestion); Bright's diseases.

**Pathology.** The hyperæmic lung has a bloated, dark red appearance, its vessels are distended to the uttermost, the tissues succulent and relaxed, blood flowing freely over the cut surface; a bloody, frothy liquid is present in the bronchi, and the alveolar walls are so much swollen that the condensed lung shows scarcely any indication of its cellular structure, resembling the tissue of the spleen (*splenification*).

**Symptoms. Active.** Rapidly developing *thoracic distress* and *difficulty of breathing*, flushed face, *strong, full pulse*, *throbbing carotids*, *cardiac palpitation* and *congested eyes*, with a short, dry *cough*, followed by scanty, frothy *expectoration* slightly streaked with *blood*.

**Passive.** Developed slowly, with difficulty of breathing, blueness of the surface, almost continuous hacking cough, followed by scanty, blood-streaked expectoration.

**Percussion.** The resonance of the lungs slightly diminished, the quality of the sound being somewhat tympanitic.

**Auscultation.** The vesicular murmur is diminished and accompanied with *sub-crepitant râles*.

**Duration. Active.** Usually from three to five days, terminating either by resolution, hemorrhage, or, rarely, pneumonia. The onset may be so severe and sudden that death rapidly supervenes.

**Passive.** Developed slowly and subject to great variations, depending upon the cause.

**Diagnosis.** Active congestion of the lungs cannot be distinguished from the stage of engorgement of a true pneumonia, in the majority of cases.

**Prognosis.** An acute congestion of the lungs may prove fatal within a few hours, but under prompt treatment it generally terminates favorably.

The passive form is controlled entirely by the cause.

**Treatment. Active.** In the strong and vigorous *wet cups* to the chest, or, if the symptoms are pronounced, a general *venesection*. Internally, *tinctura aconiti*, gtt. j-ij every half hour or hour, as indicated, with *free catharsis* with saline purgatives.

**Passive.** *Dry or wet cups* over the chest, *hydragogue cathartics*, and the internal administration of *digitalis*; if much depression of the vital powers, *stimulants* such as *spiritus vini gallici* and *ammonii carbonas* are indicated.

## ŒDEMA OF THE LUNGS.

**Definition.** An effusion of serum upon the free surface of the lung, to wit: in the pulmonary vesicles; characterized by dyspnœa, cough, and frothy, blood-streaked expectoration.

**Causes.** Result of cardiac diseases; Bright's disease; over-exertion; alcoholic excesses; mental excitement; inhalation of cold or hot air.

**Pathological Anatomy.** The lung tissue is swollen, and does not collapse when the chest is open. The elasticity of the tissue has disappeared, and it pits upon pressure.

If following congestion of the lungs, the color is red; if a symptom of a general dropsy, its color is pale.

On cutting into the œdematosus spots an enormous quantity of liquid, sometimes clear, at other times of a red color, mixed more or less with blood, flows over the cut surface. The liquid is filled with bubbles, is frothy, from being copiously mixed with air, providing the air cells have not been entirely filled with serum, thereby excluding the air.

**Symptoms.** Following a more or less rapidly developing hyperæmia of the lungs are *great oppression* of and *extreme rapidity in breathing*, with a strong sense of *oppression*, great *anxiety*, *rapid* and *tumultuous cardiac action*, *throbbing carotids and temporals*, fullness of the head and *headache*, *flushed face* and *congested eyes*, with a *constant, short cough*, and the *expectoration of a tough, frothy mucus, streaked with blood*.

If the effusion into the air cells be sufficient to prevent the entrance of air, symptoms of *cyanosis* rapidly supervene, the *pulse* becoming *feeble*, the *surface cold*, the *breathing shallow* and *hurried*, the *cough suppressed*, *stupor* replacing the restlessness, soon deepening into *coma*.

**Percussion.** Slightly impaired or vesiculo-tympanitic.

**Auscultation.** The vesicular murmur is supplanted by *subcrepitant* and *bubbling râles*.

**Diagnosis.** *Pneumonia* in the earlier stages is the only condition likely to be confounded with œdema of the lungs, and the subsequent course of the two maladies soon determines the diagnosis.

**Prognosis.** Œdema of the lungs is always a serious malady, and frequently, unless promptly relieved, terminates fatally.

**Treatment.** If the œdema be of an active kind, prompt *blood-letting*, either by *venesection* or *wet cups* to the chest, is indicated.

The *internal* administration of *tinctura aconiti*, gtt. j-ij, repeated every fifteen minutes, until the cardiac action is markedly reduced, after which every hour or two, with the use of the preparations of ammonium, either the *carbonas* or *iodidum*, to liquefy the effusion, produce marked relief.

The above means may be aided by *counter-irritation* to the chest, *hot mustard foot-baths*, active saline purgatives, and diuretics.

### CROUPOUS PNEUMONIA.

**Synonyms.** Lobar pneumonia; pneumonitis; fibrinous pneumonia; pleuro-pneumonia; lung fever; winter fever.

**Definition.** An acute croupous inflammation involving the vesicular structure of the lungs, rendering the alveoli impervious to air; characterized by a severe chill, fever, pain, dyspnœa, cough, rusty sputum and great prostration.

**Causes.** The question of pneumonia being a constitutional disease is still *sub judice*, although the belief is growing, as it presents such a marked difference from other inflammations in that it is self-limited, and terminates by crisis. It is most common in winter, at times occurring *epidemically*, the result of atmospheric conditions; exposure to draughts and cold; injuries to the chest walls; alcoholic excesses; gout or rheumatism.

**Pathological Anatomy.** The inflammatory changes most commonly affect the lower right lobe, rarely the upper lobe, very rarely corresponding lobes in both lungs.

The changes are, I. *Hyperæmia* (engorgement); II. *Exudation* (red hepatization); III. *Resolution* (gray hepatization); or it may undergo purulent transformation or the development of abscesses (yellow hepatization).

I. *Stage of hyperæmia* or engorgement consists in the vessels of the alveoli being distended to their utmost, encroaching upon the cavity of the air vesicle; the lung has a reddish-brown color, is heavier, sinking somewhat lower in water than a normal lung, and having a slight exudation upon the vesicular surface. The same changes are perceived in the adjacent bronchioles.

II. *Stage of exudation*, consists in the exudation of a viscid, fibrinous fluid, admixed with white and red corpuscles and blood, which rapidly coagulates, firmly enclosing the corpuscles and completely

filling the alveoli. When the exudation and coagulation are completed, the lung is red, sinks at once when placed in water, and its elasticity is destroyed. When cut into, the color, density and granular appearance so closely resembles the cut surface of a section of the liver, that Lænnec termed it *red hepatization*.

III. *Resolution*, or gray hepatization, follows the above condition in the majority of cases, the coagulated albuminous exudation undergoing liquefaction and absorption, the cellular element undergoing a fatty degeneration, the greater part being absorbed, the remainder expelled during acts of expectoration, the alveoli returning to their normal condition, both as to capacity, function and elasticity.

If resolution be retarded and portions of the coagulated exudation undergo *purulent transformation*, changing from a yellowish to a greenish-yellow color (yellow hepatization), pus cells are rapidly formed, the part becoming a granular, fatty mass. The portions of the lung not undergoing this purulent transformation retain the reddish color with intermixed yellowish patches, the lung structure proper remaining intact. The purulent contents may be ejected in part, the remainder undergoing fatty degeneration and finally absorption.

*Abscess of the lung* may result from the lung structure becoming involved in the purulent disintegration. Abscesses may be solitary or in great numbers, which by disintegration of intervening structure form one or more large abscesses; these abscesses either terminate fatally, or open into the pleural cavity, causing *empyema* and exhaustion, or open into the bronchi and are expectorated, or an *interstitial pneumonia* is developed and the abscess encapsulated in a firm cicatricial tissue.

*Gangrene* of the lungs may result from blocking up of the bronchial or pulmonary arteries by coagula, during any stage of the disease.

The uninflamed portions of the lungs are hyperæmic and their functional activity is increased.

Death sometimes results from a *general œdema* of the unaffected lung, such cases being often erroneously termed "double pneumonia."

If inflammation of the *pleura* be associated with a pneumonia, the so-called *pleuro-pneumonia*, the changes in the pulmonary pleura are characteristic. "An uneven, thin, downy-looking layer of plastic exudation covers its surface. This plastic layer may conceal the liver-brown color of the pneumonic lung. As the third stage is reached the opposing surfaces of the pleura may become agglutinated.

The pleuritic changes follow very closely those which occur within the lung. The cells in the pleuritic exudation are mainly pus. The pleuritic membrane is opaque, congested and ecchymotic. It may become so thick as to give a dull note on percussion, after resolution is reached."

*Duration of Stages:* *stage of congestion*, from one to three days; *stage of exudation*, from three to seven days; *stage of resolution*, from one to three weeks.

In severe cases or in the very young, the aged or the depressed, the stage of red hepatization may be fully developed within forty-eight hours.

*Seat:* The most frequent seat of croupous pneumonia is the lower right lobe; the next most frequent seat is the lower left lobe; the next, the upper right lobe, although in children and the aged this lobe is affected equally as often as the right lower lobe.

**Symptoms.** Begins with a severe and usually protracted *chill* (in children often convulsions, adults, vomiting), followed by a rapid *rise of temperature*,  $103^{\circ}$ - $104^{\circ}$  F., a strong, full, but *rapid pulse*, soon showing evidences of embarrassed *cardiac action* from obstructed respiratory circulation, either a *dull or sharp pain* near the nipple, aggravated by pressure, breathing or coughing, *shortness of breath*, the number of respirations increasing to 40, 50 or more per minute, causing *interrupted speech*; *cough*, first short, ringing and harsh, soon followed by a scanty, frothy mucus, soon becoming semi-transparent, viscid and *tenacious*, about the second day changing to the familiar *rusty sputum*, becoming more copious and of a yellow color as the disease advances; rarely cases occur with bloody or blood-streaked sputum during the continuance of the fever. There are present *headache*, *sleeplessness*, rarely *delirium*, save in drunkards, *epistaxis*, *flushed countenance*, and especially over the malar bones is a well-defined mahogany blush; *gastric disturbances* and scanty, high-colored urine, with *diminished chlorides*, often *albuminuria*.

From the very onset of the disease the prostration is of the most marked character.

The above symptoms continue more or less marked until either the *fifth, seventh, ninth or eleventh day*, when a *crisis* occurs, and within twenty-four hours convalescence is established, recovery rapidly following.

*Typhoid pneumonia* is a term applied to those cases which are

accompanied by signs of extreme prostration, delirium, tremor, very high temperature and profuse and prolonged exudation. They may also terminate by a crisis.

*Bilious pneumonia* occurs in cases accompanied by congestion of the liver, the result of venous stasis from pulmonary obstruction or from an accompanying acute catarrhal jaundice. In malarial districts pneumonia and malaria are often associated, when jaundice, more or less pronounced, occurs. Such cases are termed *malarial* or *intermittent pneumonia*.

If *purulent infiltration* follow the stage of red hepatization, instead of a crisis, symptoms of exhaustion occur, with profuse purulent expectoration, high temperature, severe sweats; the tongue brown and dry, sordes collecting on the teeth, recovery slow and convalescence tedious.

Pneumonia occurring in persons of *intemperate* habits usually begins with symptoms closely resembling an attack of *delirium tremens*, cough and expectoration, the pain very slight, or even absent.

**Inspection.** *First stage*, deficient movement of the affected side, due to the pain.

*Second stage*, the healthy side rises normally, the affected side lagging behind. If both lower lobes are impervious to air, the diaphragm cannot descend and the epigastrium does not project during inspiration, the breathing being conducted by the upper part of the chest (superior costal respiration).

**Palpation.** *First stage*, the *vocal fremitus* more distinct than normal.

*Second stage*, the *vocal fremitus* is markedly *exaggerated*, except in those rare instances of occlusion of the bronchi by secretion.

The *cardiac impulse* is felt in the normal position.

**Percussion.** *First stage*, the percussion note is slightly *impaired*; indeed, at times having a hollow or tympanitic quality.

*Second stage*, dullness over the affected parts, with an increased sense of *resistance*.

**Auscultation.** *First stage*, over affected part, feeble vesicular murmur, associated with the true vesicular or *crepitant* (crackling) *râle*, most distinct during inspiration.

*Second stage*, harsh, high-pitched *bronchial respiration*, at times resembling a to and fro metallic sound, except in those rare instances in which the bronchi are more or less filled with secretion.

*Bronchophony*, or distinctly transmitted voice, at times *pectoriloquy*, or distinct transmission of articulated sounds.

Third stage, breathing changing from bronchial to *vesiculo-bronchial*, the *crepitant* (*crepitatio redux*) *râle* returning, and if resolution proceed, the breath sounds are associated with *large* and *small moist* and bubbling *râles*.

"The morbid phenomena, physical signs and symptoms of the malady correspond usually in this manner."—(DA COSTA.)

I. Stage of engorgement and beginning exudation.	Crepitant râle; slight percussion dullness.	Cough; beginning dyspnœa and rapidly developed fever heat.
II. Stage of solidification of lung-tissue (red hepatization).	Percussion dullness; bronchial respiration; bronchophony.	Rusty-colored sputum; dyspnœa; cough; high fever, with marked evening exacerbations and morning remissions.
III. Stage of softening (gray hepatization).	The same physical signs as in the second stage, unless large abscesses have formed	Chills; prostration, etc.; purulent or brownish sputum; generally high temperature.

**Terminations.** Asthenic cases recover within two weeks. When purulent infiltration supervenes, the disease pursues a tedious course of several weeks' duration, with a low exhaustive fever.

If death occur during the first or second stages it is usually the result of a *collateral œdema* of the uninflamed lung, or *cardiac failure and impaired nerve force*.

If abscesses occur, there are exhausting sweats, frequent cough, with a large amount of yellowish-gray, at times blood-streaked, expectoration.

*Gangrene* of the lungs is a rare termination; it is associated with symptoms of collapse, the expectoration of a blackish, fetid sputum, and the physical signs of a pulmonary cavity.

**Diagnosis.** *Œdema of the lungs* may be confounded with the first stage of pneumonia, but the subsequent history, its presence on both sides, and the waterish expectoration and absence of chill and pain and the physical signs of pneumonia soon determine the diagnosis.

**Complications.** *Acute pleuritis* is a frequent complication of croupous pneumonia, occurring as often as from ten to twenty-five

per cent. of cases. The more acute localized pain, the greater embarrassment of respiration, and the usual physical signs of effusion are the evidences of a *pleuro-pneumonia*.

*Capillary bronchitis* is a rare but dangerous complication.

*Pericarditis, rheumatism and gout* are rare complications.

*Pleurisy* is oftener confounded with pneumonia than any other disease, the points of distinction between which will be pointed out when discussing that affection.

**Prognosis.** Depends upon the extent of the inflammation, the dangerous features of croupous pneumonia being cardiac failure, the result of the embarrassed respiratory circulation, and the rapid tissue waste associated with extreme fever, 105°, resulting in impaired nerve force; double pneumonia is a very grave prognosis, but is not near so frequent as was at one time supposed. The co-existence of pleuritis adds to the gravity of the prognosis, although not as fatal as it formerly was. Pneumonia of drunkards almost invariably terminates fatally. Typhoid pneumonia, the so-called bilious pneumonia, purulent infiltration, abscesses of the lungs and gangrene, all give a grave prognosis.

**Treatment.** If pneumonia be regarded as a constitutional malady with a local lesion, then the consolidated lung no more calls for treatment than does the intestinal ulcer of typhoid fever, but the general condition of the patient is to govern in the management of the case and not the local changes going on in the thorax. A simple pneumonia attacking persons previously in good health requires no more active treatment than any of the so-called self-limited diseases, provided only that the extent of the disease be moderate, and there be no complication.

The much discussed question of *venesection* is now a settled problem in the affection, if we bleed it is "*not because of pneumonia, but in spite of pneumonia*." Called to a case in the first stage of the disease, or early in the second stage, who has been vigorous and otherwise healthy, with a high temperature, 105° or more, with frequent pulse, one hundred and twenty beats or more, or a slow, full pulse showing cardiac oppression, flushed surface and marked dyspnoea, a copious bleeding is indicated, and the same may be said when symptoms of collateral oedema threaten; this is bleeding for symptoms and not for the disease *per se*.

Called to the majority of cases, during the first stage, after a rapidly acting purgative, administer *quininæ sulphas*, gr. v, with or without

*antipyrine*, gr. iij-v, every three hours until their effects are produced, using at the same time small doses of such arterial sedatives as *aconitum*, *veratrum viride* or *digitalis* until a decided impression is made on the circulation. It is also in this stage that either wet or dry cups over the chest, followed by the application of poultices, seems to act beneficially. In the feeble or aged poultices are to be used from the onset.

*Second Stage.* It is at this period of a severe attack of acute pneumonia that two prominent indications for treatment arise,—*heart-insufficiency* and *high temperature*.

To reduce the temperature, we have at least two safe and reliable drugs, if administered in sufficient amounts. I refer to *quininæ sulphas* and *antipyrine*. The dose of *quininæ sulphas* as an antipyretic in pneumonia is gr. x-xv, repeated as needed. The doses of thirty and forty grains recommended I have never seen required; in fact, it would seem to me to be contraindicated on account of the cardiac depression such amounts would produce. *Antipyrine* is also a very reliable antipyretic either alone or combined with the quinine. The use of the cold pack or of cold baths for reducing the temperature in acute pneumonia has not met with the approval of practical clinicians.

To sustain the heart is one of the most important indications in the treatment of an acute pneumonia, for experience shows that cardiac failure is responsible for a large number of deaths in this affection. Without question, *alcoholic stimulants* judiciously employed are the most efficient means for preventing or overcoming the cardiac failure. The amount can only be determined by a careful study of each case, as a few ounces in the twenty hours may answer in one case, while another may require eight or ten ounces. It is well to begin with small doses, increasing or decreasing as its effects are good or bad. *The indicator of the heart's condition is the pulse.* In the aged, the feeble, or in those accustomed to the use of alcohol, stimulation is indicated from the onset. Other indications would be a frequent, feeble, irregular or intermitting pulse; a dicrotic pulse; delirium, muscular tremor and subsultus; immediately following crisis, and the period of collapse.

Other cardiac stimulants that may be used are *ammonii carbonas*, *digitalis* and *moschus*.

It is also during this period that the diet must be of the most nutritious but easily digestible character, and given at periods of every three hours.

*Third Stage.* The treatment is a continuation of the second stage, gradually reducing the antipyretics as the fever declines, and adding one of the preparations of *ferrum*.

*Convalescence.* Nutritious diet, quininæ sulphas in tonic doses, ferrum, together with a good blood-making wine or a good preparation of malt. If the consolidation shows a disposition to linger, blisters may be used.

The various symptoms other than those particularly mentioned are to be met, as they arise, by their proper remedies.

For typhoid pneumonia, purulent infiltration, abscess of the lungs, or pneumonia in drunkards, the weak or the aged, *quinina*, *ferrum*, *nutritious* diet and bold *stimulation*, and the free use of *ammonii carbonas* are the indications.

The so-called *antiseptic* treatment of acute pneumonia is still under trial, and no definite opinion can be expressed concerning it.

## CATARRHAL PNEUMONIA.

**Synonyms.** Broncho-pneumonia ; lobular pneumonia ; capillary bronchitis (?).

**Definition.** An acute catarrhal inflammation of the bronchioles and alveoli of the lungs characterized by fever, cough, dyspnœa, copious expectoration and great depression.

**Causes.** From an extension of a bronchial catarrh downward ; following the eruptive fevers, especially measles ; complicating whooping cough. Persons of the rickety or scrofulous diathesis, in whom there is a greater irritability of the epithelial elements, are particularly predisposed to this form of pneumonia on slight exposure ; emphysema ; diseases of the heart ; most frequently seen in childhood and old age.

**Pathological Anatomy.** *Hyperæmia* of the mucous membrane of the bronchi, and also of the bronchioles and air cells, with *swelling* and *succulence* of these tissues, accompanied by an *abnormal secretion* and an immense *production of young cells* from the proliferation of the bronchial and alveolar epithelium, admixed with a yellowish, creamy, mucoid material, which blocks up the bronchioles and air cells.

The affected parts first have a reddish-gray, soon changing to a yellowish-gray color, due to the rapid metamorphosis of the newly

developed cells. If the fatty change be completed, absorption takes place, and the consolidation is removed; if it remain incomplete the cells atrophy, the little mass becoming caseous, and the disease passes into a chronic state.

The bronchial tubes also participate in the disease, the walls become thickened, from a hyperplasia of the connective tissue (*peri-bronchitis*), and their calibre is often dilated.

**Symptoms.** Catarrhal pneumonia begins as a catarrhal bronchitis. It may be either *acute*, *sub-acute* or *chronic* in its course.

*Acute variety:* Its onset is announced by a gradual rise of temperature to  $102^{\circ}$ - $103^{\circ}$  F., the febrile phenomena assuming a typical remittent character, with *rapid*, laborious and shallow *breathing*, as shown by the widely dilated nares and violent action of all the accessory muscles, while the insufficient distention of the lungs is shown by the great recession of the lower part of the chest walls and sinking in of the intercostal spaces. The *inspiration* is short and imperfect, the *expiration* noisy and prolonged; the *pulse* is frequent, 100-120 or more, and somewhat compressible; the *cough*, which, during the bronchitis, was loose, now becomes *short*, *hacking*, dry and *painful*, soon followed by more or less copious *muco-purulent expectoration*; the appetite is impaired, *bowels* somewhat *loose*, urine scanty, high-colored, and the surface frequently covered with a more or less *profuse perspiration*.

The *sub-acute* and *chronic* varieties have the same general symptoms, but the duration is longer and the exhaustion greater.

The progress of catarrhal pneumonia is sometimes, although not often, a very acute one. The disease may prove fatal in a few days, especially if it attack feeble children; in such the countenance becomes pale and livid, the lips bluish, the eyes dull, and a restlessness giving place to apathy and a continually augmented somnolence.

Resolution, when it occurs, is by *lysis*, several weeks elapsing before complete recovery.

**Percussion.** *Dullness*, scattered in patches, over both lungs, the intervening healthy lung often giving a more or less *hollow* or *tympanitic* note.

**Auscultation.** *Vesiculo-bronchial breathing*, changing to moist bronchial breathing, associated with *small bubbling* (sub-crepitant) *râles*. As the disease progresses toward resolution, the *râles* become

larger (large bubbling) and more copious. If pneumonic phthisis result, physical signs indicative of that condition are soon evident.

**Sequelæ.** Attacks of catarrhal pneumonia complicated with atelectasis, or collapse of the lobules, when recovery occurs, are followed by emphysema of the lungs.

If the catarrhal products which fill the alveoli and bronchioles and intervening connective tissue do not rapidly undergo complete fatty metamorphosis and consequent absorption, *pneumonic phthisis* results.

**Diagnosis.** *Ordinary bronchial catarrh* differs from catarrhal pneumonia by the absence of dyspnœa, fever, and dullness on percussion, and the presence of the large bubbling râles, and also by the subsequent history of the two affections.

*Croupous pneumonia* is a unilateral disease; catarrhal pneumonia is bilateral and diffused over both lungs; the former a self-limited disease, the latter having no fixed duration.

*Acute tuberculosis* at its onset is characterized by the presence of a capillary bronchitis, a differentiation being possible only by a study of the clinical history and course of the two maladies.

*Œdema of the lungs* is a bilateral disease associated with a short, dry cough and dyspnœa, but lacks the previous catarrhal history and high temperature of catarrhal pneumonia.

**Prognosis.** Fully one-half of the cases of true catarrhal pneumonia terminate fatally. The prognosis must be guarded in scrofulous or rachitic subjects, or those enfeebled by other diseases, for, unless prompt resolution can be effected, it will terminate fatally early, or develop pneumonic phthisis. Have seen cases continuing up and down for eight and ten months, and finally make a good recovery.

**Treatment.** Confinement to bed is paramount, although the position of the patient is to be frequently changed. The diet must be of the most nutritious character, administered at frequent intervals; milk, eggs, chicken, beef, mutton and oyster broths are the most suitable. The steady use of *brandy* or *whisky* throughout the attack is of importance; regulating the amount by the age of the patient and the severity of the attack.

For the fever, *quininæ sulphas*, gr. xv–xx each day, is the most reliable of all antipyretics, or *antipyrine* in full doses may be substituted.

For the *catarrhal process*, the air of the apartment should be main-

tained at an even temperature and moistened by disengaging the vapor of water in it. The following combination is of great utility in nearly all cases, regulating the dose in accordance with the age of the patient :—

R.	Ammonii carbonat., . . . . .	gr. v
	Ammonii iodidi, . . . . .	gr. v-x
	Mucil. acaciae, . . . . .	q. s.
	Syr. glycyrrh., . . . . .	3 ij-ij
	Syr. prun. virg., . . . . .	q. s. ad 3 ij-iv. M.

SIG.—Every three hours.

A much pleasanter way of administering the ammonia salts is in capsules, each containing about two and one-half grains of each salt with an aromatic oil. *Terpene hydrate* acts remarkably well in many cases.

For convalescence, nutritious food, *ferri iodidum*, *quinina sulphas*, and *oleum morrhua*.

Locally : repeated application of mustard poultices or turpentine stapes followed by demulcent poultices. If the inflammatory process tends to become chronic, scattering blisters should be used.

## PULMONARY CONSUMPTION.

**Synonyms.** Phthisis pulmonalis ; phthisis ; consumption.

**Definition.** Four varieties of pulmonary consumption are now admitted to exist : Pneumonic phthisis ; tubercular phthisis ; fibroid phthisis ; acute miliary tuberculosis.

As these forms present differences at all points, they will be described separately.

## PNEUMONIC PHTHISIS.

**Synonyms.** Chronic catarrhal pneumonia ; catarrhal phthisis ; caseous pneumonia ; caseous phthisis.

**Definition.** A form of pulmonary consumption characterized by the destruction of the pulmonary tissue resulting from the *caseation* or cheesy degeneration of inflammatory products in the lungs and the subsequent softening and destruction of the caseous matter, with greater or less destruction of the pulmonary tissue ; characterized by hectic fever, cough, shortness of breath, purulent expectoration, and more or less rapid prostration.

**Causes.** The *predisposing* factor in the etiology of pneumonic phthisis is a strumous or scrofulous diathesis, or a condition of lowered health, the result of various unfavorable hygienic influences.

The *exciting* causes are catarrhal pneumonia in any portion of the lung, but especially at the *apex*; inflammation occurring about a blood clot; inhalation of irritant particles occurring in certain occupations, to wit: weaving, grinding, mining, hatters, millers, cigar makers and the like.

**Pathological Anatomy.** When a pneumonia terminates in resolution the inflammatory products are absorbed by first undergoing a *fatty metamorphosis*. If the fatty metamorphosis be incomplete, the cells are atrophied and undergo the *caseous degeneration*, which consists in the absorption of the watery parts and the fatty degeneration of the cellular elements and the granular disintegration of the fibrinous material, so that ultimately a soft, solid mass is produced, yellowish in color, having the appearance of cheese.

The destructive changes are thus described by Niemeyer: "Cells, the products of inflammation, accumulate in the alveoli and minute bronchi, crowd upon each other, becoming densely packed, and thus by their mutual pressure they bring about their own decay, as well as that of the lung textures, by interfering with their nutrition, the alveolar walls being also themselves damaged by the inflammatory process."

The position of the catarrhal pneumonia resulting in the above changes is usually at the apex, but it may occur at any portion of the lungs, or a whole lung becomes infiltrated, and undergoes the cheesy degeneration (*phthisis florida*).

In many cases *tubercle* is deposited in the inflamed lung, hastening its destruction and the formation of cavities.

**Symptoms.** Pneumonic phthisis occurs in three forms, the *chronic*, the *sub-acute* and the *acute*.

**Chronic form.** The origin is rather insidious, the individual being susceptible to "colds," or "catarrhs," on the slightest exposure; gradually a *persistent cough*, with the *expectoration of muco-pus*, is established, each severe cold being accompanied with *chill*, *fever*, *pain in the chest*, and either slight *hemorrhage* or *blood-streaked sputa*. Finally the catarrhal symptoms become persistent, with morning *chills*, evening *fevers* and rather profuse *night sweats*, distressing cough, profuse muco-purulent sputa, great weakness and exhaustion, loss of appetite and feeble digestion, the symptoms

growing persistently worse, death occurring from *exhaustion* after one or two years' duration.

*Sub-acute variety.* History of an acute attack of pneumonia of one or two weeks' duration, followed by a decided improvement, but not complete recovery. After a lapse of some weeks or months, symptoms of pulmonary *softening* begin, destroying the lung structure and forming cavities, accompanied by *chills, fever, night sweats, emaciation, cough, muco-purulent and blood-streaked expectoration*, the patient dying from exhaustion within a year.

*Acute variety*, the so-called *phthisis florida*, runs a rapid course, beginning as a catarrhal pneumonia, involving the whole of one or part of both lungs, associated with rapid *loss of flesh* and strength, *high but variable temperature, 103°–105° F.*, with remissions, profuse *night sweats, shortness of breath, severe cough, profuse, purulent and blood-streaked sputa, loss of appetite, feeble digestion, rapid emaciation*, the patient succumbing in a few weeks or months, from exhaustion.

A decided remission in the local and general symptoms of the acute variety may occur, the disease afterward pursuing a more chronic course.

**Inspection.** Shows *deficient respiratory movements* of the diseased portion of the lungs.

**Palpation.** *Increased vocal fremitus* over the consolidated lung tissue and cavities.

**Percussion.** The percussion note varies from a slight *impairment* of the normal note to *dullness*, and when cavities are formed, associated with scattered points of the *tympanitic* or *hollow* note. If the cavities communicate with a bronchial tube the *cracked-pot* or *cracked-metal* sound is elicited. If the cavities are filled with pus the percussion note is *dull*. If the pus be expelled, the *tympanitic* or *cracked-pot* sound returns.

**Auscultation.** The vesicular murmur is unimpaired in those parts free from disease: it is *feeble* or *indistinct* if many bronchioles are obstructed; and is *harsh* or *blowing* if the bronchioles are narrowed. The *inspiratory* sound will be *jerking*, and the *expiratory* sound *prolonged* and *blowing* when the lung has lost its elasticity.

Associated with the impaired vesicular murmur is a *fine, dry, crackling sound* (*crepitation*), appearing at the *end of inspiration*. If bronchitis be associated, large and small *moist* or *bubbling râles* are heard during the respiration.

When cavities form, either bronchial or broncho-cavernous respiration is heard, associated with more or less distinct *gurgling râles*. If the cavity be free from pus and have rather firm walls, the breathing is more *amphoric* in character.

**Diagnosis.** *Catarrhal bronchitis* has many points of resemblance to pneumonic phthisis. The subsequent course of the latter, with the high temperature, prostration, emaciation, and physical signs, should prevent error.

*Tubercular phthisis* is often confounded with pneumonic phthisis, an error difficult to prevent in many cases.

**Prognosis.** *Acute variety*, the phthisis florida, usually terminates fatally within a few months.

The *sub-acute* and *chronic* varieties may, under judicious treatment and favorable hygienic conditions, be arrested, the caseous matter partly expectorated and partly absorbed, leaving more or less loss of structure, cicatricial tissue supplying its place, which after a time contracts, causing more or less contraction of the chest walls.

Cases not properly treated, either from carelessness or poverty, succumb after a year or two.

**Treatment.** An attempt should always be made to remove the caseous matter by absorption and expectoration. The following prescriptions will sometimes prove successful:—

R.	Ammon. carb., . . . . .	gr. v	
	Ammon. iodidi, . . . . .	gr. v-x	
	Syr. tolu, . . . . .	3 ij	
	Syr. prun. virg., . . . . .	3 ij.	M.

Every five hours, alternating with

R.	Liq. potassii. arsenitis, . . . . .	m v	
	Mass. ferri carb., . . . . .	gr. v	
	Vini xeric, . . . . .	3 j	
	Aquæ dest., . . . . .	q. s. ad f $\frac{2}{3}$ ss.	M.

The diet should be of the most nutritious character, the clothing warm, and, if practicable, change of residence should be made to a dry and elevated climate. If the digestion will permit, *oleum morrhœa*, 3j-ij, three times a day.

For the fever, *quininæ sulphas*, gr. xv-xx, is more successful than the combination of quinina and digitalis in small doses; experience has demonstrated that the antipyretic properties of *quinina* are markedly increased if rest in bed for the time being be enjoined.

Loomis has found that the antipyretic properties of quinina in phthisis are increased by the addition of morphina to each dose.

*Night sweats* are best controlled by *atropinæ sulphas*, gr.  $\frac{1}{80}$ , at bedtime, or

R. Extract. belladonnæ, . . . . .	gr. ss	
Zinci oxidi, . . . . .	gr. iiij.	M.

At bedtime.

For the *cough* and *sleeplessness*, *codeinæ sulphas*, gr. ss-j, p. r. n.

## TUBERCULAR PHTHISIS.

**Synonyms.** Tuberculosis; consumption; incipient phthisis.

**Definition.** The deposition of tubercle in the lung structure, which undergoes softening, followed by more or less loss of the pulmonary tissue proper; characterized by fever, cough, dyspnœa, emaciation and exhaustion.

**Causes.** Chiefly hereditary; closely associated with scrofula and struma; probably contagious under certain conditions; secondary to catarrhal (caseous) pneumonia; the theory of the "*bacillus tuberculosis*" of Koch is still *sub judice*.

**Pathological Anatomy.** Tuberclæ are grayish-white, translucent and semi-solid granulations, about the size of a millet seed, most commonly deposited in the walls of the bronchioles, exciting a low form of inflammation, the result of its own death. The masses of tubercle soon undergo softening (cheesy transformation); the lung structure is secondarily affected, undergoes softening, which results in more or less destruction of the tissue, whence cavities are formed.

The inflammation may extend to the small arteries, causing hemorrhage.

The deposit of tubercle is generally at one of the apices, soon spreading to other parts; depositions may also occur in the brain, intestines and liver.

The pleura is usually the seat of a chronic inflammation (dry pleurisy), resulting in the obliteration of the pleural cavity.

**Symptoms.** The symptoms correspond closely to the stages of deposition, of softening, and of the formation of cavities.

The development is *insidious*, with increasing *dyspepsia*, *irritable heart*, a light, dry, hacking *cough*, referred to the throat or stomach,

scanty, glairy *expectoration*, gradual loss of weight, impaired muscular strength, pallid appearance, more or less copious *haemoptysis* often following. Pain, sharp in character, below the clavicles, is often present.

The beginning of softening is announced by increased *cough*, freer *expectoration*, *dyspnœa* increased on exertion, morning *chills*, evening *fever*, *night sweats*—the so-called *hectic fever*, *diarrhœa*, increased *emaciation* and *weakness*, the patient, however, continuing very hopeful.

With the formation of the cavities, the *cough* is more aggravated, with profuse and purulent *expectoration*, at times containing yellow striæ, the amount depending upon the number and size of the cavities; *haemoptysis* not common at this stage; the *pulse* rapid and weak, increased *hectic*, burning of the soles and palms, copious *night sweats*, greater debility and *emaciation*, with *œdema* of the feet and ankles, denoting failure of the circulation, death soon following from asthenia, the mind clear and hopeful to the end.

**Inspection.** First stage, often shows slight *depressions* in the supra-clavicular, and at times in the infra-clavicular regions.

**Palpation.** Second stage, the *vocal fremitus* is slightly increased.

**Percussion.** First stage, slight impairment of the normal *percussion resonance* can sometimes be elicited. Second stage, the resonance is impaired, and may be even dull. Third stage, dullness with circumscribed spots of the *amphoric*, or *tympanitic* or cracked-pot sound.

**Auscultation.** First stage, *inspiration jerky*, *expiration prolonged*, the pitch higher than normal, the inspiration associated with crackling *râles*.

Second stage, *vesiculo-bronchial breathing*, associated with *sub-crepitant* and large and moist or *bubbling râles*.

Third stage, *bronchial*, *broncho-cavernous* and *cavernous respiration*, associated with large and small moist or *bubbling*, and localized *gurgling râles*.

*Bronchophony* in its various degrees is associated with the second and third stages of tuberculosis.

**Complications.** Tubercular diseases of the brain, larynx, pleura, intestines and peritoneum; perineal abscess leading to fistula.

**Diagnosis.** The early diagnosis of tubercular phthisis rests mainly on the history, together with the symptoms and physical signs.

In the first stage it is often mistaken for dyspepsia, anaemia, malarial fever, or disease of the heart.

**Prognosis.** In the main unfavorable, although under proper treatment, change of climate and like favorable conditions, life may be prolonged for years. The question of perfect recovery is, to say the least, doubtful.

**Treatment.** While I have never seen a case of incipient phthisis cured in the broad acceptation of that term, I have repeatedly seen life prolonged for a number of years, and the deposition of tubercle long delayed by a change of climate early in the history of the case, warm clothing, life and exercise in the open air short of fatigue, and systematic bathing and a nutritious plan of dieting. If the diet is arranged in accordance with the appetite, the latter will gradually increase, but should it not, it may be stimulated by such bitters as *nucis vomicis*, *ignatia amara*, *colombo* or *gentian*.

The symptoms are to be met as they arise, and drugs are not to be used simply because the patient has the physical signs of beginning tubercle. For the general debility and malaise that accompanies the early stages of this malady, any one, or a combination of the following drugs, exercising care that they in no way interfere with the appetite: *Ol. morrhuae*, *ferri iodidum*, *arsenicum*, *hypophosphites*, or the *elixir quininæ ferri et strychninæ*.

Great temporary improvement in the symptoms of phthisis sometimes follows the *rectal injection* of *sulphuretted hydrogen* after the manner suggested by M. Bergeon, of Paris, but that recovery will occur is hardly probable.

Dr. H. C. Wood suggests the administration of the remedy by the stomach, claiming as great success by that means as when administered per rectum. To cover the disagreeable taste of the remedy he uses a *saturated solution* of the sulphuretted hydrogen, using: "At first half an ounce, afterwards an ounce, of the saturated solution of the sulphuretted hydrogen should be placed in a tumbler, and two or three ounces of carbonic acid water be run into it from a highly-charged siphon, the whole being drunk while effervescing. This may be given three to five times a day, so that the patient will receive daily between half a pint and a pint of the sulphuretted hydrogen gas."

Special symptoms require treatment only when indicated, care being exercised to avoid everything which tends to impair the appetite, disorder digestion, or lower the vital powers.

For the *fever* the "Niemeyer pill" is usually recommended; its formula being—

R.	Quininæ sulph.,	gr. j.	
	Pulv. digitalis,	gr. ss	
	Pulv. opii,	gr. $\frac{1}{4}$	
	Pulv. ipecac,	gr. $\frac{1}{4}$	M.

From a very considerable experience with this "famous" pill, I can recall few cases in which it has proven of the least benefit. The following is much more effectual:—

R.	Quininæ sulph.,	gr. x	
	Quininæ muriat.,	gr. x	
	Pulv. opii et ipecac,	gr. iiij.	M.

Ft. capsul No. ij.

SIG.—One capsule five hours, and the other three hours before the decided rise of temperature.

For *night sweats*, not the result of the diurnal fever, *atropinæ sulphas*, gr.  $\frac{1}{60}-\frac{1}{80}$ , at bedtime, is an effective agent. It is claimed that *sulphonal*, gr. viij-x, at bedtime, controls the night sweats and also produces a quiet, refreshing sleep.

For *cough*, if not modified by the arrest of temperature and night sweats, the following is of use:—

R.	Codeinæ sulphat.,	gr. $\frac{1}{3}-\frac{1}{2}$	
	Acid. hydrocyanici dil.,	mij	
	Syr. tolu,	3j.	M.

SIG.—Several times a day.

The *dyspeptic* symptoms are wonderfully relieved by the following:—

R.	Pepsini cryst.,	gr. ij	
	Acid. muriat. dil.,	mij	
	Glycerini,	mij	
	Succi limonis,	mij	
	Aquaæ aurantii flor. ad,	3ij.	M.

SIG.—With meals.

### FIBROID PHTHISIS.

**Synonyms.** Chronic interstitial pneumonia; cirrhosis of the lungs; Corrigan's disease.

**Definition.** A hyperplasia (thickening) of the pulmonary connective tissue, resulting in atrophy and degeneration of the vesicular

structure, associated with bronchial inflammation ; characterized by cough, profuse expectoration, fever, emaciation, and ultimately death by asthenia.

**Causes.** Hereditary ; inhalation of irritants ; chronic bronchitis ; alcoholism.

**Pathological Anatomy.** Thickening of the bronchial mucous membrane and dilatation of the air tubes ; hyperplasia of the pulmonary connective tissue, resulting in the compression and consequent destruction of the vesicular structure, which is assisted by the contraction of the newly formed tissues. Sooner or later catarrhal pneumonia results, the product undergoing the cheesy degeneration, cavities being formed, and as a result of the long-continued suppuration, tubercular depositions occur, hastening the destruction of the lung tissue.

Prof. Da Costa has reported a number of cases of "grinder's phthisis," in whose sputum was found the "bacillus tuberculosis," in whose family history there were no traces of consumption.

**Symptoms.** The course is chronic, beginning as a *bronchial catarrh*, worse in winter, better in summer, when, after several years, the *cough* becomes more *continuous*, the *expectoration* freer and muco-purulent, often raised in paroxysms, in large amounts, *hectic fever* develops, *night sweats*, *dyspnæa* and rapid *emaciation*, soon followed by *œdema* of the feet and ankles, the result of failing circulation, death occurring by asthenia.

**Inspection.** Depression of the chest walls.

**Percussion.** Impaired resonance, followed by *dullness*, with irregular spots of amphoric or *tympanitic* percussion note over the points of depression.

**Auscultation.** First stage, *vesiculo-bronchial*, or harsh respiration associated with large and small, moist or *bubbling râles*, followed by *bronchial*, *broncho-cavernous* and *cavernous* respiration, with circumscribed *gurgling râles*.

**Diagnosis.** Beginning as a bronchial catarrh, slowly progressing, with the remission of the symptoms during the summer months, finally becoming progressively worse, with the formation of cavities, and symptoms of asthenia, are the chief points in the diagnosis.

**Prognosis.** The duration of fibroid phthisis is most protracted, six or twelve years being the average duration ; death, however, is the inevitable termination.

Prof. Da Costa has records of one hundred deaths from "grinder's consumption" whose average life was twelve years.

**Treatment.** To prevent the hyperplasia of the connective tissue, *hydrargyri corrosivum chloridum, potassii iodidum or aurii et sodii chloridum*, are recommended. *Oleum morrhuae* is of benefit.

The bronchial catarrh, hectic fever and night sweats should be treated only when their severity becomes marked.

### ACUTE PHTHISIS.

**Synonyms.** Acute miliary tuberculosis; galloping consumption.

**Definition.** An acute febrile affection, due to the rapid deposition throughout the body, but especially in the lungs, of the gray tubercle-granule: characterized by high fever, rapid pulse, hurried respiration, pain in the chest, cough, profuse expectoration and rapid prostration.

**Causes.** Most common between puberty and middle life.

"That the gray granulation is deposited throughout the body under the influence of certain conditions of irritation, it is necessary that a peculiar vulnerability of the constitution exist, in other words, that it be of the scrofulous type."

The result of caseous or suppurative changes in the lungs.

**Pathological Anatomy.** "The gray granulation or miliary tubercle consists of a fine reticulation of fibres, with a mass of epithelioid cells and granules, and often having a giant cell for its centre."

The deposit is generally over both lungs and the bronchial tubes, and is followed by hyperæmia, increase of secretion, having a viscid and adhesive character, and the destruction of all the tissue with which it comes in contact.

Deposits also take place in the brain, pleura, intestines, peritoneum and kidneys.

**Symptoms.** The onset is usually sudden, with a *chill* or *chilliness*, followed by *fever*,  $102^{\circ}$ - $104^{\circ}$  F., *rapid*, *dicrotic pulse*,  $120$ - $140$ , *cough*, with scanty, glairy sputum, *increased respiration*,  $30$ - $50$  per minute, *pain* in the chest, hot skin, dry tongue, deranged digestion and *great prostration*, the severity of the symptoms rapidly increasing, the sputum becoming more abundant and often rusty in color, with more or less frequent attacks of *haemoptysis*, soon followed by headache, vertigo, sleeplessness, often delirium, coma and death.

If deposits have occurred in the meninges or the intestines, symptoms of these affections are superadded.

**Percussion.** The percussion resonance is normal until considerable deposits have occurred, when it is either slightly *impaired* or even slightly *tympanitic*. With the development of cavities the *amphoric* percussion note is present.

**Auscultation.** *Vesiculo-bronchial* breathing, associated with large and small, moist or *bubbling râles*, soon followed by *bronchial* and *broncho-cavernous* breathing, with large and small, moist and circumscribed *gurgling râles*.

**Duration.** Acute phthisis terminates fatally in from four to twelve weeks.

**Diagnosis.** Commonly mistaken for typhoid fever with lung complications, an error that is readily made unless a close study of the history, symptoms and physical signs be made.

**Treatment.** There are no means of retarding the progress of this malady. Loomis says: "Morphia in small doses—one-twentieth of a grain hypodermically every six or eight hours—has, in my hands, been more satisfactory in staying the progress of the disease, prolonging life, and keeping the patient comfortable, than any other plan."

Dr. McCall Anderson claims that subcutaneous injections of atropina check the exhausting sweats; and that quinina, digitalis and opium reduce the temperature, and if they fail, ice cloths to the abdomen will accomplish the desired result.

The various symptoms should be met as they occur, the patient at the same time being supplied with large quantities of *stimulants*.

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## DISEASES OF THE PLEURA.

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### PLEURISY.

**Synonyms.** Pleuritis; "stitch in the side."

**Definition.** A fibrinous inflammation of the pleura, either *acute*, *subacute* or *chronic* in character, occurring either idiopathically or secondarily; characterized by a sharp pain in the side, a dry cough,

dyspnoea and fever. It may be limited to a part, or may involve the whole of one or both membranes.

**Causes.** *Idiopathic* pleuritis is said to be due to cold and exposure, to injuries of the chest walls, or the result of muscular exertion.

*Secondary* pleuritis occurs during an attack of pneumonia, pericarditis, rheumatism, smallpox, Bright's disease, or puerperal fever.

*Chronic* pleurisy follows an acute attack, or is the result of tuberculosis, Bright's disease, or alcoholism.

**Pathological Anatomy.** The course pursued by an inflammation of a serous membrane is *hyperæmia* followed by *exudation of lymph*, the *effusion of fluid*, its *absorption* and the *adhesion* of the membranes.

The *first or dry stage* of pleurisy is hyperæmia or diffused, irregular redness of the membrane, with little specks of exudation. The *second stage* is characterized by the copious exudation of lymph, more or less completely covering the membrane, giving it a dull, cloudy, or shaggy appearance. If the inflammation ceases at this point, it is termed *dry pleurisy*. The *third*, or stage of effusion, is characterized by the pouring out of a semi-fibrinous liquid; more or less completely filling and distending the pleural cavity, and floating in the fluid are fibrinous flocculi, blood and epithelial cells.

*Absorption* of the fluid and more or less of the exudative lymph soon occurs, the unabsorbed portion becoming organized, forming adhesions which obliterate the pleural cavity.

The effusion, if on the right side, pushes the heart further to the left; if on the left side, the heart is displaced to the right, the impulse often being seen to the right of the sternum. The lungs are also compressed and displaced upward and against the spinal column, and, on removal of the fluid, expand again, except in cases of chronic pleurisy, when the functional activity of the pulmonary structure is more or less permanently impaired.

*Chronic pleurisy* results when the fluid is not absorbed or when it is effused into the cavity in a slow and insidious manner. The membrane is irregularly thickened, with firm adhesions, fluid being found in the meshes, and depressions of the thoracic walls also occurring. The fluid may be serum, pus (*empyema*), or pus and blood. Openings may form, through which there is a permanent discharge, either externally (fistulous empyema) or into the bronchi, or rarely, into the bowels.

**Symptoms.** *Acute attack:* Begins with a *chill*, followed by a sharp lancinating *pain* (stitch) near the nipple or in the axilla, aggravated by coughing and breathing, associated with slight *tenderness on pressure*. The *respirations* are *rapid* and *shallow*, 30-35 per minute, a short, dry, hacking *cough*, moderate *fever*, compressible pulse, 90-120. With the effusion of liquid the *dyspnœa* becomes aggravated, the *cough* more distressing, the *cardiac action* embarrassed, the *countenance* wearing an anxious expression, the patient usually lying on the affected side. With the absorption of the fluid the symptoms gradually ameliorate, convalescence being more or less rapid.

*Subacute attack:* Begins insidiously after cold, exposure and fatigue in those enfeebled. Patients usually complain of a *sense of weariness*, *shortness of breath*, aggravated on exertion, *evening fever*, followed by *night sweats*, short, harassing *cough*, none or very scanty sputum; the *pulse* is small, feeble but frequent, 100-120 beats per minute. The characteristic pain in the side is usually wanting.

*Chronic variety*, irregular chills, fever, night sweats, dyspnœa, palpitation, embarrassed circulation, with more or less prostration.

**Inspection.** *First stage*, deficient movement of the affected side, on account of the pain induced by full breathing.

*Second stage*, bulging or fullness of the affected side, with obliteration of the intercostal spaces and displacement of the cardiac impulse.

**Palpation.** *Second stage*, vocal *fremitus* feeble or absent over the site of the effusion, exaggerated *above* the site of the fluid. Rarely, *fluctuation* may be obtained.

**Percussion.** *First stage*, may be slightly *impaired*.

*Second stage*, dullness or even flatness over the site of the effusion; *tympanic* percussion note above the fluid.

**Auscultation.** *First stage*, feeble vesicular murmur over the affected side, the patient breathing superficially, to prevent the pain; a friction sound, slight and grating or creaking, becoming louder as the exudation of lymph increases, limited usually to the angle of the scapula of the affected side, rarely heard over the entire side, accompanies the respiratory movements.

*Second stage*, feeble or absent vesicular murmur on the affected side, depending upon partial or complete compression of the lungs by the fluid. Above the fluid puerile breathing, and just at the upper margin of the fluid a friction sound may be heard.

The *vocal resonance* is diminished or absent over the site of the

fluid and markedly increased above, *aegophony* being present at the upper margin of the fluid.

With the absorption of the fluid the vesicular murmur gradually returns, associated with a moist friction sound.

**Diagnosis.** *Acute pneumonia* is often mistaken for the effusion stage of pleurisy. The points of distinction are, in pneumonia there is the pronounced chill, high fever, and characteristic sputa, bronchial breathing, exaggerated vocal fremitus and resonance, and no displacement of the heart, the reverse occurring in pleurisy.

*Enlargement of the liver* may be mistaken for pleurisy with effusion, the chief point of distinction being that, in enlargement of the liver, the superior line of dullness is depressed upon full inspiration, while in pleurisy with effusion inspiration does not modify the location of the dullness.

**Prognosis.** *Idiopathic* pleurisy usually terminates in recovery within three weeks. Pleurisy the result of constitutional causes has its prognosis modified by the condition with which it is associated. *Empyema*, unless the result of a diathesis, terminates favorably. *Double pleurisy* is unfavorable.

**Treatment.** At the onset, in plethoric patients, *wet cups* over the affected side; if great dyspnoea, severe pain and high arterial tension, even *venesection*, and in anaemic or weak persons, *dry cups*, following the use of either wet or dry cups with poultices or turpentine stapes. The severe pain is promptly relieved by the hypodermic injection of *morphinæ sulphas*, over its site, repeated as indicated, or the frequent use of small doses of *pulvis opii et ipecacuanhæ*.

*Tinct. verat. virid.*, or *tinctura aconiti*, in small doses, frequently repeated, in the plethoric, and *digitalis* in the weak, control the circulation, and lessen the amount of blood distributed to the affected membrane.

After effusion has begun, *extractum pilocarpi fluidum*, gtt. xx, every two or three hours, or in drachm doses every other day for a week or two, after which twice weekly, or—

R. Potassii acetat., . . . . .	gr. xxx	
Infus. digitalis, . . . . .	3 ij.	M.

Every three or four hours.

If the effusion be uninfluenced by the above, use *potassii iodidum*, gr. xv, every four hours, with flying blisters over the affected side; or

the fluid may be evacuated by *aspiration*, using at the same time full doses of *mistura ferri et ammonii acetatis* (*Basham's mixture*). Locally in the arm-pits, groins, or over the site of the effusion, *unguentum hydrargyri*.

The effusion of pleuritis is rapidly removed by the method of treatment suggested by Prof. Matthew Hay, of Scotland, consisting in the use of a concentrated solution of saline cathartics, "order the patient to take nothing after the evening meal, and then, an hour or so before breakfast, the salt is given dissolved in as little water as possible. Usual dose from  $\frac{3}{4}$ iv-vj to  $\frac{5}{6}$ j-ij magnesii sulphatis to an ounce or two of water, no fluids to be used after the dose ; this usually produces from four to eight watery stools without pain or discomfort and also acts as a diuretic."

The essence of the "Hay method" consists in getting the concentrated solution into the intestines at a time when the fluid contents are scanty.

If *double pleuritic effusion*, evacuate the fluid at once with the *aspirator*, and use the potassium and digitalis mixture mentioned above.

*Chronic pleurisy* : if the effusion be still serous, it is often absorbed by the internal use of *potassii iodidum*, alternating with "*Basham's mixture*," and *blisters*, the secretions being regularly attended to. If, however, the liquid is pus (*empyema*), the *aspirator* should be used at once, the patient placed upon "*Basham's mixture*," *stimulants* and *quinina*.

Usually, however, within a very few days after aspiration, another accumulation of pus will have taken place. Should this occur, the purulent pleurisy should then be treated as an abscess, an incision being made between the fifth and sixth ribs, the pus evacuated, a drainage tube introduced and an antiseptic dressing applied. If the tendency to pus secretion still remains the pleural cavity must be washed out with an antiseptic solution, the constitutional treatment being continued.

### HYDROTHORAX.

**Synonym.** *Dropsy of the pleura.*

**Definition.** The effusion of fluid into the pleural cavities (bilateral), the result of a general dropsy from renal or cardiac disease.

**Pathological Anatomy.** More or less clear serous fluid in both pleural sacs, compressing the lungs. No signs of inflammation are present.

**Symptoms.** Following dropsy of the abdomen occurs *dyspnœa*, with signs of deficient blood aeration, both lungs being compressed.

**Palpation.** Absent vocal fremitus over the site of the fluid.

**Percussion.** Dullness over the site of the fluid.

**Auscultation.** Absent vesicular murmur over the site of the fluid.

**Diagnosis.** Easily determined by association of the symptoms with a general dropsy.

**Prognosis.** Controlled by the cause producing the general dropsy.

**Treatment.** Depending upon the condition causing the dropsy. *Dry cups* over the chest afford relief. If the symptoms of non-aeration of the blood are severe, the fluid should be at once evacuated with the *aspirator*.

## PNEUMOTHORAX.

**Synonyms.** Air in the pleural cavity; hydropneumothorax.

**Definition.** The accumulation of air in the pleural cavities, with the consequent development of inflammation of the membranes; characterized by sharp pain, followed by rapidly developing dyspnœa and cough.

**Causes.** Generally the result of tubercular phthisis, causing perforation of the pleura. Perforation may take place from the pleura into the lung, in connection with empyema or abscess of the chest walls. Direct perforation from without, by laceration of a fractured rib or severe contusion.

**Pathological Anatomy.** The gas in the pleural cavity consists of oxygen, carbon anhydride, and nitrogen in variable proportions. It may fill the pleural sac completely, compressing the lung, or is sometimes limited by adhesions. The gas tends to excite inflammation, the resulting effusion being either serous or purulent.

**Symptoms.** Symptoms of pneumothorax, the result of perforation, are sudden or sharp pain in the side, intense dyspnœa, attended with symptoms of collapse, coldness of the surface and cold sweats.

The above symptoms, in many instances, follow a severe or violent paroxysm of coughing. In severe cases there is never a moment's cessation of the acute pain and distressing dyspnœa, causing orthopnoea from the onset until death.

**Inspection.** Enlargement of the affected side, the intercostal spaces being widened and effaced, or even bulged out so that the surface of the chest is smooth. Respiratory movements of the affected side are diminished or absent.

**Percussion.** Immediately after the rupture the percussion note is hyper-resonant, or even tympanitic or amphoric in quality. If the amount of air in the pleural cavity becomes extreme there is dullness on percussion, associated with a feeling of great resistance or density. When effusion of blood occurs dullness is observed over the lower part of the chest, hyper-resonant or tympanitic percussion note over the upper portions of the chest, these sounds changing as the patient changes his position.

**Auscultation.** The normal vesicular murmur may be diminished or absent. The typical amphoric respiratory sound is heard when the fistula is open, usually associated with a metallic echo.

*Metallic tinkling*, or the bell sound, is sometimes distinctly produced by breathing, coughing or speaking, after the development of inflammation of the pleura.

The vocal resonance may be diminished or absent, or, rarely, it may be exaggerated, with a distinct metallic echo.

After the development of inflammation in the pleura, suddenly shaking the patient gives rise to a *splashing sensation*, the succussion sound, if both air and fluid are present in the pleural cavity.

**Prognosis.** When occurring as the result of tuberculosis, the prognosis is extremely unfavorable; rarely, the fistulous opening being enclosed by inflammatory action; the case then becomes one of chronic pleurisy.

**Treatment.** At once a hypodermic injection of *morphinæ sulphas*, which relieves the severe pain and somewhat modifies the distressing dyspnœa, followed by the evacuation of the fluid and air with the *aspirator*.

If the fistulous opening be closed by inflammatory action, the case resolves itself into one of chronic pleurisy, the treatment indicated for that affection plus the treatment of tuberculosis, being the indication.

## DISEASES OF THE CIRCULATORY SYSTEM.

The methods employed in making a physical examination of the heart are: I. *Inspection*. II. *Palpation*. III. *Percussion*. IV. *Auscultation*.

**Inspection** indicates the exact point of the *cardiac impulse*, and whether there be any abnormal *pulsations* or any change in the form of the *præcordium*.

Normally the *impulse* is visible only in the *fifth interspace*, midway between the left nipple and the left border of the sternum, its area covering about one square inch, most distinct in the thin, while often barely seen in the very fleshy; often displaced downward by full inspiration and elevated by complete expiration.

Disease may alter the *position* and *area* of the *impulse*.

The *position* of the *impulse* is moved to the right by left pleuritic effusions; downward by hypertrophy or emphysema; upward by pericardial effusion.

The *area* of the *impulse* is changed and enlarged by pericardial adhesions, cardiac dilatation, or hypertrophy.

**Palpation** confirms the observations of inspection, and also determines the *force*, *frequency* and *regularity* of the *cardiac impulse*.

The *impulse* is *diminished* by cardiac dilatation, fatty degeneration of the heart, emphysema, pericardial effusion, and adynamic diseases.

The *impulse* is *increased* by cardiac hypertrophy, during the first stage of endocarditis and pericarditis, functional cardiac disturbances and sthenic inflammations.

**Percussion** will indicate the boundaries of the *superficial* and *deep cardiac space*, the so-called *præcordium*. It is essential that the upper, lower, and two lateral boundaries of the pericardial region be memorized, to wit: *superior boundary*, the upper edge of the third rib; the *lower boundary* is a horizontal line passing through the fifth intercostal space; the *left lateral boundary* is about or a little within a vertical line passing through the nipple, the *linea mammalis*; and the *right lateral boundary* is an imaginary vertical line situated one-half an inch to the right of the sternum. These boundaries vary

somewhat in health, but are sufficiently accurate for all practical purposes.

*The superficial cardiac space* represents that portion of the heart uncovered with lung; it is triangular in form, its apex being the junction of the lower border of the left third rib with the sternum, its area not exceeding two inches in any direction.

The superficial space is *increased* by cardiac hypertrophy, dilatation or pericardial effusion.

*Diminished* at the end of full inspiration or by emphysema.

*The deep cardiac space* represents that portion of the heart covered by lung, and extends from the upper border of the third rib to the lower edge of the fifth interspace, and from half an inch to the right of the sternum to near the left nipple.

It is *increased* by hypertrophy or dilatation of the heart, left pleuritic effusion, and apparently increased by consolidation of the anterior border of the investing lung.

**Auscultation** indicates the character of the normal cardiac sounds and the point of greatest intensity at which they are heard, and should be thoroughly familiarized if abnormal sounds are to be fully appreciated.

The ear or stethoscope applied to the praecordium distinguishes *two sounds*, separated by a momentary silence—the *short pause*, and the second sound followed by an interval of silence—the *long pause*.

*The first sound*, corresponding to the contraction of the heart—the *systole*—is louder, longer and of lower pitch and a more booming quality than the second sound, and has its point of greatest intensity at the cardiac apex or a little to the left. It corresponds closely to the pulsations as felt in the carotid or radial arteries.

*The second sound* is shorter, weaker and higher in pitch than the first sound, and has a clicking or valvular quality, having its point of greatest intensity at the second right costal cartilage and a little above, and corresponds to the closure of the aortic and pulmonary valves. The sound made by the closure of the tricuspid valves is best isolated at the ensiform cartilage. The sound made by the closure of the pulmonary valves at the third left costal cartilage.

The extent of surface over which the cardiac sounds are heard varies, according to the size of the heart and the condition of the adjacent organs for transmitting sounds.

The cardiac sounds may be altered in *intensity, quality, pitch, seat*

and *rhythm*, or they may be accompanied, preceded or followed by adventitious or new sounds, the so-called *endocardial murmurs*.

*The intensity is increased* by cardiac hypertrophy, irritability of the heart or consolidation of adjacent lung structure.

*The intensity is diminished* by cardiac dilatation or degeneration, during the course of adynamic fevers, emphysematous lung overlapping the heart, or pericardial effusion.

*The quality and pitch* of the first sound may be sharp or short and of higher pitch when the ventricular walls are thin the valves being normal ; its pitch and quality are also raised during the course of low fevers. The second sound becomes duller and lower in pitch when the elasticity of the aorta is diminished or the aortic valves thickened. Either or both sounds have a more or less metallic quality in irritable heart and during gaseous distention of the stomach.

*The seat of greatest intensity* of the cardiac sound is changed by displacement of the heart, pleuritic effusion, pericardial effusion, and abdominal tympanites.

*The rhythm* is often interrupted by a sudden pause or silence, the heart missing a beat, or the sounds are irregular, confused and tumultuous, the result of organic changes in the cardiac muscles, valves, or orifices ; or a reduplication of one or both sounds of the heart may occur.

The *adventitious cardiac sounds or murmurs* are of two kinds, those made external to the heart, as *pericardial*, *exocardial* or *frictional murmurs*, and those made within the cardiac cavity, *endocardial murmurs*.

*Pericardial murmurs*, or friction sounds, are made by the rubbing upon one another of the roughened surfaces of the pericardial membrane during the early stages of inflammation. The sounds have a rubbing, creaking, or grating character, and are differentiated from a pleural friction sound by their being limited to the praecordium, synchronous with every sound of the heart, and not influenced by respiration.

They are distinguished from an endocardial murmur by their superficial rubbing, creaking or grating character, and by not being transmitted beyond the limits of the heart, either along the course of the vessels, or to the left axilla, or back.

*Endocardial murmurs* are of two kinds, to wit : *organic* and *functional*.

*Functional endocardial* or blood murmurs are the result of changes in the natural constituents of the blood.

Their character is soft, they are heard most distinctly at the base to the left of the sternum, during the systole, are not transmitted beyond the limits of the heart, either to the left axilla or the back, and are associated with general anaemia.

*Organic endocardial murmurs* are produced by blood currents pursuing either a normal or an abnormal direction.

In health there are two direct blood currents upon each side of the heart, to wit: the current from the left auricle to the left ventricle, the *mitral direct current*; the current from the left ventricle to the aorta, the *aortic direct current*; the current from the right auricle to the right ventricle, the *tricuspid direct current*, and the current from the right ventricle to the pulmonary artery, the *pulmonic direct current*.

When, from disease, the valves are not properly closed, the blood is allowed to flow back against the direct current producing abnormal blood currents, to wit: when the mitral valve is incompetent, the blood flows from the left ventricle back to the left auricle during the cardiac systole, producing the *mitral regurgitant or indirect current*; when the aortic valves are incompetent, the blood is permitted to flow from the aorta into the left ventricle during the cardiac systole, producing the *aortic regurgitant or indirect current*; when the tricuspid valves are incompetent, the blood flows from the right ventricle back into the right auricle during the systole, producing the *tricuspid regurgitant or indirect current*; when the pulmonary valves are incompetent, the blood flows from the pulmonary artery into the right ventricle, producing the *pulmonic regurgitant or indirect current*.

The *mitral direct current* occurs during the contraction of the left auricle, or just before the first sound of the heart and immediately after its second sound. The *aortic direct current* is produced by the contraction of the left ventricle, and occurs with the first sound of the heart. The *tricuspid direct current* occurs during the contraction of the right auricle, or just before the first or immediately after the second sound. The *pulmonic direct current* is produced by the contraction of the heart, occurring during its first sound.

The *mitral direct, or presystolic murmur*, occurs before the first sound of the heart and immediately after the second sound. It is caused by a narrowing of the mitral orifice, has a blubbering quality,

well imitated by throwing the lips into vibration by the breath, of a low pitch, and it has its seat of greatest intensity at the cardiac apex, and is not transmitted to the left axilla or to the base of the heart.

*The mitral regurgitant, or systolic murmur*, occurs with the first sound of the heart, resulting from the failure of the mitral valves to close the mitral orifice during the systole, in consequence of which the blood flows back, or regurgitates into the left auricle. It is usually of a blowing or churning character, and has its seat of greatest intensity at the cardiac apex, being well transmitted to the left axilla and inferior angle of the left scapula.

*The aortic direct murmur* occurs with the first sound of the heart. It is caused by a narrowing of the aortic orifice, has a rough or creaking character, is of high pitch, having its seat of greatest intensity in the second intercostal space, to the right of the sternum, and is well transmitted over the carotid artery.

*The aortic regurgitant murmur* occurs with the second sound of the heart, and is caused by the failure of the aortic valves to close the aortic orifice during the diastole, whereby the blood flows back or regurgitates into the left ventricle. It is usually of a blowing or churning character and of low pitch, having its seat of greatest intensity over the base of the heart, and is well transmitted downward toward or below the cardiac apex. It is the only organic murmur produced in the left side of the heart which occurs with the second sound of the heart.

*The tricuspid direct murmur* occurs before the first sound of the heart and immediately after the second sound. It is caused by a narrowing of the tricuspid orifice, has a blubbering quality, and is low in pitch, having its seat of greatest intensity near the ensiform cartilage. This murmur is exceedingly rare.

*The tricuspid regurgitant murmur* occurs with the first sound of the heart, the result of the failure of the tricuspid valves to close the tricuspid orifice during the systole, thus allowing the blood to flow back or regurgitate into the right auricle. It is usually of a blowing or soft, churning character, having its seat of greatest intensity at the ensiform cartilage. This murmur is also very infrequent, and occurs mostly when the right ventricle is considerably dilated, without the existence of any valvular disease.

*The pulmonic direct murmur* occurs with the first sound of the heart. It is generally connected with congenital lesions. It occurs

at the same instant that the aortic direct murmur occurs, and is distinguished from the latter by its not being transmitted into the carotid artery, whereas the aortic direct murmur is always thus transmitted.

The pulmonic regurgitant murmur occurs, like the aortic regurgitant murmur, with the second sound of the heart. This murmur is exceedingly rare, and its presence is only positively differentiated from the aortic regurgitant murmur by the absence of aortic lesions and symptoms.

### ACUTE PERICARDITIS.

**Definition.** An acute fibrinous inflammation of the pericardium; characterized by slight fever, pain, praecordial distress and disturbed cardiac action and circulation.

If the inflammation be limited to the parietal or visceral layer, or to a part of either, it is termed *partial* or *circumscribed* pericarditis; if it involve the whole of both surfaces it is termed *general* or *diffused* pericarditis.

**Causes.** May follow injuries of the chest walls, or be the result of taking cold, but generally secondary to either acute articular rheumatism, pneumonia, pleurisy, erysipelas, Bright's disease or pyæmia.

**Pathological Anatomy.** The same as serous membranes in other situations.

*Hyperæmia* of the membrane, most marked on the visceral layer, followed by the exudation of lymph scattered in irregular patches, giving it a rough and shaggy appearance (*dry pericarditis*), followed by the effusion of a sero-fibrinous fluid, with flocculi floating on it, and at times mixed with blood. Rarely, the fluid is purulent.

The fluid and lymph undergo absorption with resulting adhesions identical with those described under pleurisy.

**Symptoms.** Acute pericarditis may be well marked and still present none of the characteristic subjective symptoms. It usually begins with *rigors*, *fever* of the remittent type, frequently nausea and vomiting, *praecordial distress*, acute shooting pains, increased by breathing and coughing, *tenderness*, dry, suppressed *cough*, *increased cardiac action* and sometimes violent palpitation. An attack of pericarditis secondary to an existing disease presents no marked symptoms other than those mentioned to indicate its onset. Duration of this early stage from a few hours to a day.

*Effusion stage:* the symptoms of this stage depend upon the amount

and rapidity of the effusion: *praecordial oppression*, tendency to *syncope*, *dyspnoea*, sometimes amounting to *orthopnoea*, *dysphagia*, *hiccup*, *nausea* and *vomiting*, feeble, irregular *pulse*, sometimes either *melancholia*, *delirium*, or acute *maniacal excitement*.

*Absorption* is generally rapid, the heart remaining "irritable" for a long time after. If instead of absorption, the fluid accumulates, and life is not destroyed, the pericardial sac becomes dilated, chronic *pericarditis* resulting.

**Inspection.** *Early stage*, excited cardiac action is evidenced by the impulse.

*Effusion stage*, feeble, undulatory or absent impulse, its position displaced upward, or rarely, downward; bulging of the praecordium and protruding abdomen.

**Palpation.** *Early stage*, excited or tumultuous impulse; *pericardial friction fremitus* rare.

*Effusion stage*, feeble or absent impulse, and if present its position is changed.

**Percussion.** *Early stage*, normal.

*Effusion stage*, cardiac dullness enlarged vertically and laterally, and if considerable fluid, of a *triangular shape*, with the base of the triangle on a line with the sixth rib, extending from the right of the sternum to the left of the left nipple, narrowing as it proceeds upward to the second rib, or above, which represents the apex of the triangle. The shape of the dullness is sometimes altered by changing the position of the patient.

**Auscultation.** *Early stage*, excited cardiac action, and usually a *friction sound* (*exocardial murmur*) synchronous with cardiac sounds and uninfluenced by respiration, but often increased by pressure with the stethoscope.

*Effusion stage*, cardiac sounds feeble and deep-seated at the cardiac apex, becoming louder and distinct toward the cardiac base. The friction sound is sometimes heard at the cardiac base.

If *absorption* occur the above signs gradually give place to the normal, the friction sound returning, of a churning, or clicking, or grating character, gradually disappearing.

**Diagnosis.** *Endocarditis* is often confounded with *pericarditis*, the points of distinction between which will be pointed out when discussing that affection.

*Cardiac hypertrophy* or *dilatation* is sometimes confounded with

pericardial effusion; the difference between them will be pointed out when discussing those affections.

*Hydropericardium* may be mistaken for pericardial effusion; see that affection.

**Prognosis.** Controlled by the severity of the inflammation and coexisting affections. If slight effusion, favorable. Death has rapidly occurred when a large quantity of fluid has been rapidly effused, the patient being really drowned in his own fluid. *Adherent pericardium* is a frequent sequela.

**Treatment.** *Perfect rest* in bed; for vigorous patients, the application of *leeches* or *wet cups* to the praecordium, followed by the application of either *ice* or *poultices*; in the feeble *dry cups* to the praecordium, followed by poultices.

*Early stage*; in the strong, control the excited cardiac action by small doses of *aconitum* or *veratrum viride*, in the feeble using *digitalis*; in all cases *quinina* is indicated.

*Effusion stage*; as the effusion progresses the free administration of *alkalies*, to wit: *ammonii carb.*, gr. v, every two hours, with *liquor ammonii acetatis*, or *potassii acetatis*, or *potassii carbonatis*, with *quinina*, nutritious liquid diet and *stimulants*, being cautious with the use of cardiac sedatives or tonics.

If the effusion has a tendency to linger, *blisters* to the praecordium, or *paracentesis*, is indicated. Dr. Roberts, in his monograph, gives an account of sixty cases of paracentesis with twenty-four recoveries. He advises that the tapping be done in the fossa between the ensiform and costal cartilages on the left side, or in the fifth left interspace near the junction of the sixth rib with its cartilage.

## CHRONIC PERICARDITIS.

**Definition.** A chronic inflammation of the pericardium, with either distention of the sac by fluid or adhesions of the pericardium (*adherent pericardium*); characterized by impaired cardiac action and disturbances of the circulation.

**Causes.** Almost always the result of an acute attack.

**Pathological Anatomy.** If the effusion be absorbed, the pericardial surfaces are *agglutinated* by several layers of lymph, which increase the thickness of the membranes half an inch or more, and the outer surface of the pericardium becomes adherent to the chest walls.

If the fluid be not absorbed it may progressively accumulate, distending the sac in all directions, displacing the diaphragm and interfering with the functions of the surrounding viscera, or a low grade of inflammation supervenes, the fluid becoming purulent, the disease terminating fatally after a variable period.

As much as eight to ten pints of fluid have accumulated in the sac.

**Symptoms.** *Precordial pain* and *distress*, irregular, feeble cardiac action, *dyspnœa* aggravated by movement and *disturbed circulation*.

An agglutinated pericardium seriously increases the danger from an attack of any pulmonary inflammation.

**Inspection.** If the effusion be present, bulging of the praecordium and displacement of the impulse.

If adhesions are formed between the praecordial surfaces as well as with the chest walls, inspection reveals *depression of the precordium*, narrowing of the spaces, increased extent but displaced impulse, uninfluenced by deep inspiration, and *recession* of the intercostal spaces (*systolic dimpling*) and epigastrium with every systole of the heart, the result of the adhesions.

**Palpation.** If effusion, displaced, feeble or absent impulse; if adhesion, displaced and tumultuous impulse; occasionally a pericardial fremitus is distinguished.

**Percussion.** If effusion, the dullness has more or less the character described for acute pericarditis.

If adhesions, the cardiac dullness is but slightly modified.

**Auscultation.** If effusion, cardiac sounds feeble and deep-seated at the apex, louder and more distinct at the cardiac base.

If adhesions, cardiac sounds are heard with equal distinctness in their several positions, associated with a rough friction sound (exocardial murmur.)

**Treatment.** If effusion, *blisters* to the praecordium, with *potassii iodidum* to hasten absorption, the patient supported by nutritious diet, *quinina*, *ferrum* and *stimulants*, and perfect quiet. If these means fail to remove the fluid, or if the fluid be purulent, *paracentesis* should be performed at once.

If adhesions of the pericardium have resulted, the application of blisters to the praecordium with the administration of *potassii iodidum*, alternating with *ferrum* and *quinina* are indicated, with nutritious diet, stimulants and perfect quiet.

## HYDRO-PERICARDIUM.

**Synonym.** Pericardial dropsy.

**Definition.** The accumulation of water in the pericardial sac, *minus* inflammation; characterized by praecordial distress, disturbed cardiac action, dyspnoea and dysphagia.

**Causes.** Usually a part of a general dropsy; Bright's disease; sudden pneumothorax; pressure of an aneurism or other mediastinal tumor; disease or thrombosis of the cardiac veins.

**Pathological Anatomy.** The fluid may range in quantity from an ounce to one or two pints, and is of a clear, yellowish or straw-colored serum, at times turbid or bloody, and of an alkaline reaction.

If the amount of fluid be large the sac is dilated, its walls thinned by the pressure, and has a sodden appearance.

**Symptoms.** Dropsy of the pericardium is so generally associated with hydrothorax that the symptoms are but an aggravation of those attending upon that condition, to wit: *disturbed cardiac action, dyspnoea, dysphagia, dry cough, and feeble circulation.*

The physical signs are exactly those of the stage of effusion of pericarditis, *minus* a friction sound.

**Diagnosis.** Pericarditis with effusion and hydro-pericardium present nearly the same signs and symptoms, a differentiation being possible only by a history of the case and the symptoms of the attack.

**Prognosis.** Controlled entirely by the cause.

**Treatment.** Depends upon the cause of the attack. If the amount of fluid in the pericardial sac be great, paracentesis will give relief.

## ACUTE ENDOCARDITIS.

**Synonym.** Valvulitis.

**Definition.** An acute fibrinous inflammation of the serous membrane lining the cavity of the heart and forming its valves; characterized by cough, dyspnoea, nausea and vomiting, disturbed cardiac action, resulting in changes in the valves or orifices of the heart.

Acute endocarditis occurs in two distinct forms: *plastic* or simple exudative endocarditis; *ulcerous* or diphtheritic endocarditis.

**Causes.** Usually secondary to acute articular rheumatism, pleuritis, pneumonia, pericarditis or Bright's disease. In the ulcerative or diphtheritic variety, a depressed condition of the vital forces, probably the result of the diphtheritic poison, seems to be the determining cause.

**Pathological Anatomy.** Inflammation of the endocardium is usually limited to the left side of the heart after birth, during foetal life the reverse being the case. The inflammation is limited or especially marked at the valvular portions of the endocardium, owing probably to the presence of fibrous tissue beneath the membrane in these situations, and to the strain which falls upon the valves during the performance of their functions.

*Hyperæmia* from congestion of the vessels beneath the membrane, with considerable swelling of the valves, the result of an *exudation of lymph and serum* beneath and on the free surface of the membrane covering the valves and *chordæ tendineæ*, resulting in the roughening of the surfaces and the agglutination of the mitral valves to each other, and of the aorta segments to the walls of the aorta, or the proliferation of the endocardial connective tissue, forming the nuclei of the so-called *warty excrescences* or *vegetation*, their size being increased by the deposit of fibrin from the blood within the cavities of the heart.

These vegetations may be detached by friction, giving rise to *emboli* which may be washed by the blood current on the left side of the brain, into the kidneys and spleen.

In the ulcerative variety a process of softening takes place in the fibrinous deposits, leading to ulcerations and perforations.

**Symptoms.** This affection is usually masked by the course of another disease until disturbances of the circulation direct attention to the heart.

The onset is often by *increase of temperature*, *præcordial distress*, *short cough*, slight *dyspnoea*, more or less persistent *vomiting*, *increased cardiac action*, often rapid and tumultuous, with *throbbing carotids* and noises in the ear. As the inflammation progresses, the cardiac action and pulse decline in rapidity, with more or less congestion of the lungs and venous stasis.

**Auscultation.** Shows a change in the character of the sounds or the development of murmurs at the various orifices, the character and points of distinction between which will be pointed out when discussing valvular diseases of the heart.

**Duration.** Between one and three weeks.

**Diagnosis.** *Pericarditis* is distinguished from endocarditis by the character of the physical signs. In pericarditis the murmur or friction sound is heard with either sound, is near to the ear and influenced by

pressure of the stethoscope, besides being associated with more or less alteration in the size and shape of the cardiac dullness, and is not transmitted, while in endocarditis the murmur takes the place of, or is associated with, the cardiac sounds, and is transmitted, with the absence of change or increased dullness on percussion.

**Prognosis.** Acute endocarditis is not very dangerous to life, hence a favorable prognosis may be given; regarding the ultimate results of valvular lesions, however, the prognosis is grave.

**Treatment.** *Perfect rest in bed.* At the onset leeches or *teet cups* to the praecordium, followed by ice, or, what is preferable, *poultices*.

The excited circulation should be controlled by *azmitum*, *veratrum viride*, or *digitalis*.

The free administration of *alkalies*, to wit: *ammonii carbonas*, *potassii acetis* or *carbonas*, until the urine is decidedly alkaline, may prevent permanent changes in the valves or orifices.

If alkalies fail and the inflammation shows a tendency to linger, good results are often obtained by a slight *hydrargyrum* impression.

If signs of oppressed circulation appear, the hands becoming blue, the face and extremities oedematous, with congestion of the lungs, the free use of *ammonii carbonas*, *digitalis* and *stimulants* are indicated. The free use of *ammonii carbonas* will often prevent or break up heart clots. After the acute symptoms have subsided, more or less absorption of the exuded lymph has followed the free use of *potassii iodidum*. During the entire course of the affection the diet should be of the most nutritious character.

### ACUTE MYOCARDITIS.

**Definition.** An inflammation of the muscular tissue of the heart, by extension from an inflamed pericardium or endocardium, or secondary to pyæmia; characterized by pain, feeble circulation, symptoms of blood poisoning and collapse.

**Causes.** The result of endocarditis or pericarditis; pyæmia; typhoid fever; emboli of the coronary arteries.

**Pathological Anatomy.** Discoloration and softening of the cardiac substance and the infiltration of a sero-sanguineous fluid, fibrinous exudation and pus, leading to the formation of abscesses in the muscular structure of the heart.

The disease leads to the formation of either a cardiac aneurism or

to rupture of the walls of the heart. If recovery occur, cicatrices or depressed scars may mark the site of a former abscess.

**Symptoms.** The clinical evidences of inflammation of the cardiac muscle are very obscure. If, during the course of one of the maladies mentioned, there are developed *pain*, irregular and feeble *cardiac action*, *pyrexia* of a low type, with symptoms of *blood poisoning*, and a tendency to *collapse*, or the symptoms of the so-called *typhoid state*, myocarditis may be suspected.

**Diagnosis.** The existence of myocarditis can scarcely ever be anything but a presumption, the signs being all negative rather than positive. If during the course of rheumatism, pyæmia, puerperal fever, typhoid fever, pericarditis or endocarditis, symptoms of cardiac failure appear suddenly, associated with signs of blood poisoning and collapse, inflammation of the cardiac muscle may be suspected.

**Prognosis.** The course of acute myocarditis is very rapid, death being the usual termination, in from three to five days. Chronic myocarditis pursues a very latent course.

**Treatment.** Largely symptomatic. Perfect rest of mind, generous diet, free stimulation and the administration of *quinina* and *ferrum*.

### CARDIAC HYPERTROPHY.

**Definition.** An overgrowth or increase in the muscular tissue which forms the walls of the heart; characterized by forcible impulse, over-fullness of the arteries, diminished blood in the veins and accelerated circulation.

**Causes.** Obstruction to the outflow of blood, to wit: aortic stenosis; emphysema; Bright's disease; functional over-action; excessive use of tobacco, tea, coffee, or excessive muscular action.

**Varieties.** I. *Simple hypertrophy*, or a simple increase in the thickness of the cardiac walls; II. *Eccentric hypertrophy*, increase in the cardiac walls and dilatation of the cavities, to wit: *Dilated hypertrophy*; III. *Concentric hypertrophy*, increase in the cardiac walls and decrease of the cavities, a very rare form.

**Pathological Anatomy.** Hypertrophy of the heart is usually limited to the left side, the ventricles more commonly than the auricles, the latter dilating.

The shape of the heart is altered by hypertrophy; if the right ventricle, the heart is widened transversely and the apex blunted; if

the left ventricle, the heart is elongated and, as a rule, the cavity is dilated; if both ventricles are hypertrophied, the heart has a globular shape. From increase in weight the heart may sink lower during the recumbent position, thereby lessening the area of cardiac dullness, but during the sitting or upright posture it sinks lower in the chest and to the left, causing more or less prominence of the abdomen.

The increase in the size of the organ is a true increase or hypertrophy of the muscular tissue, and not a hyperplasia. The tissue is firmer and the color brighter and fresher than when the size of the organ is normal.

**Symptoms.** Depend upon the amount of hypertrophy. The most common are *increased and forcible cardiac action*, the arteries becoming fuller, the veins less full and the circulation accelerated, *pulsating carotids and aorta, headache, often vertigo, frequent epistaxis, congestion of the face and eyes, tinnitus aurium, dyspnoea on exertion, dry cough, restless nights, with more or less jerking of the limbs, occasional precordial pains shooting toward the left axilla, full, firm, bounding pulse, and pulsations in the superficial arteries.*

A sphygmographic tracing shows the line of ascent vertical and abrupt, but the apex is rounded, and the line of descent is oblique, unless there is more or less insufficiency of the valves.

**Inspection.** Often fullness or prominence of the praecordium, with distinct impulse.

**Palpation.** The impulse is felt one or two intercostal spaces lower down and to the left, and is stronger and more or less diffused —the heaving impulse.

**Percussion.** The area of cardiac dullness is increased vertically and transversely upon the left side of the sternum, unless the right ventricle is also hypertrophied, when the cardiac dullness is increased to the right of the sternum.

**Auscultation.** If simple hypertrophy without any coexisting changes in the valves or orifices, the first sound has a loud and somewhat metallic quality, the second sound being strongly accentuated.

**Sequelæ.** Cerebral hemorrhage; miliary cerebral aneurisms; dilatation of the heart; fatty changes in the cardiac tissue.

**Diagnosis.** Hypertrophy of the heart can scarcely be mistaken for any other disease if a careful study of the physical signs be made.

**Prognosis.** When the result of valvular disease, the hypertrophy is said to be compensatory. If the result of Bright's disease, emphy-

sema of the lung, or if occurring late in life, or associated with atherosomatous degeneration of the vessels, the prognosis is unfavorable; when the result of functional over-action in the strong and robust, a further enlargement can often be prevented by active and persistent treatment.

**Treatment.** The indications are to *lessen the force* and *number* of the cardiac pulsations and to *remove the cause* whenever possible.

The former indications are best met by the persistent use of *aconitum* in small doses, gtt. j-ij, three times a day, or *veratrum viride*, gtt. j-ij, three times a day, at the same time keeping the bowels, kidneys and the skin acting freely.

The habits of the patient are to be corrected, all laborious or active exercise to be restricted, the patient to be in the recumbent posture several hours during the day if possible, the diet being restricted, avoiding all forms of stimulants, such as liquors, tobacco, tea and coffee.

Cases of cardiac hypertrophy associated with Bright's disease are relieved by *digitalis*, the cardiac distress being secondary to the kidney disease for which the digitalis is used.

Cases of cardiac hypertrophy associated with anaemia should, in addition to the above, be placed upon a course of *ferrum*.

## DILATATION OF THE HEART.

**Definition.** An increase in the size of one or more of the cavities of the heart, without any increase or thickening of the cardiac walls; in fact, the walls are frequently thinner; characterized by feebleness of the circulation, terminating in venous stasis, oedema and exhaustion.

**Causes.** Over-exertion in those of feeble resisting powers, as youths or soldiers, as first pointed out by Prof. Da Costa; insufficiency of the valves; emphysema; chronic bronchitis; gout; Bright's diseases.

**Varieties.** I. *Simple dilatation*, the cavities being enlarged, the walls normal. II. *Active dilatation*, corresponding to eccentric hypertrophy; the cavities being enlarged and the walls increased in thickness, the so-called "dilated hypertrophy." III. *Passive dilatation*, the cavities being enlarged and the walls thinned or stretched.

**Pathological Anatomy.** The right side of the heart is far more frequently involved than the left side. The shape of the organ

is altered, according to the part affected. The weight of the organ is, as a rule, increased, as hypertrophy almost always accompanies or precedes dilatation.

The muscular tissue is generally pale, mottled and softened, and under the microscope presents evidences of degeneration. The orifices also participate, and especially the auriculo-ventricular, resulting in the valves becoming incompetent to close the orifices, and this latter effect is added to by the removal of the basis of the papillary muscles to a great distance from the orifice, in consequence of the extension of the wall.

When the auricles dilate, the large venous trunks opening into them unprotected by valves commonly participate in the dilatation, and may become greatly enlarged.

The passive congestion of the organs that follows the feeble circulation produces changes in their structure.

**Symptoms.** Those associated with enfeebled circulation, to wit: *feeble pulse*, veins distended, arteries emptied, *headache*, aggravated by the upright position, attacks of *syncope*, *cough*, with any of the following phenomena of venous congestion; of the lungs, *dyspnoea*; liver, *jaundice*; stomach, *dyspepsia*; intestines, *constipation*; kidneys, *scanty often albuminous urine*; brain, *dullness* of the mind and *vertigo*, often relieved by a copious epistaxis; and, finally, *dropsy*, beginning in the lower extremities, the patient dying from exhaustion.

Great relief often temporarily follows any of the above symptoms under treatment; sooner or later, however, the venous stasis produces the final symptoms noted.

**Inspection.** Veins of the surface distended and enlarged; indistinct cardiac impulse, often diffused and wavy; if associated with tricuspid insufficiency, there is pulsation of the jugular.

**Palpation.** Feeble and irregular fluttering but heaving impulse.

**Percussion.** Cardiac dullness extended transversely, and especially increased on the right side.

**Auscultation.** If no valvular lesion accompany the dilatation the cardiac sounds are weaker than normal, the first sounds having a sharper quality than normal; if accompanied by valvular lesions, cardiac murmurs are present.

**Diagnosis.** *Hypertrophy* of the heart shows increased cardiac dullness, and is a disease of powerful cardiac action, while dilatation is an affection of feeble action associated with dropsy.

*Pericardial effusion* has many points of resemblance to cardiac dilatation, but it begins suddenly, associated with some acute malady; and while the heart sounds are indistinct or feeble at the apex, they both have their normal qualities at the cardiac base, while dilatation of the heart has a chronic history, results in general venous stasis, the cardiac sounds being of the same intensity over the entire praecordia.

**Prognosis.** Unfavorable, death resulting from gradual exhaustion, or suddenly by cardiac paralysis if there be undue excitement.

**Treatment.** Dilatation of the heart is incurable. Palliative measures are of but temporary benefit. In all cases there are two important indications to be met, the first to maintain the general nutrition of the patient to the uttermost, and the second to control or prevent all irregular or violent cardiac action. The first indication is accomplished by a generous diet, moderate exercise, with *bitters* to increase the appetite and *ferrum* to improve the blood, and, in a majority of cases, the more or less free use of a good *red wine*.

The second indication is met by the observance of strict rules in regard to exercise and such heart tonics as *digitalis* in powder or infusion, *tinctura strophanthus*  $\text{mij-x}$ , t. d., *ext. convallariae flid.*, gtt. v, t. d., *quinina*, *caffeina* and *morphinæ sulph.*, in small doses, the latter when the dropsy becomes great and associated with marked cyanosis, hypodermically, as suggested by Prof. Bartholow, "often acts like magic in restoring the circulation."

The following pill is often of great advantage,—

R.	Ferri redact., . . . . .	gr. j-ij	
	Quininæ sulph., . . . . .	gr. j-ij	
	Pulv. digitalis, . . . . .	gr. j	
	Morphinæ sulph., . . . . .	gr. $\frac{1}{24}$	M.

SIG.—Three times a day.

The secretions should be stimulated by *purgatives*, *diuretics* and *diaphoretics*.

If pulmonary congestion, *dry cups*, *digitalis* and *stimulants*.

For cardiac asthma, *dry cups*, *morphinæ sulph.* hypodermically, or *spts. ætheris compositus* (Hoffman's Anodyne).

For hepatic congestion, *blue mass* or *podophyllin*.

For dropsy, *dry cups* over the kidney, *digitalis* or *potassii acetas*, with *scoparius* and *juniperus*, and *pulv. jalapæ comp.*,  $3\frac{1}{2}$ -ij, in water, before breakfast.

If the dropsy is uninfluenced by the above means, success will follow the use of *hydrargyri chloridi mite*, gr. iij, guarded with *pulv. opii*, gr.  $\frac{1}{2}$ , three or four times a day, as I have frequently witnessed.

### FATTY DEGENERATION OF THE HEART.

**Definition.** A change in the muscular fibres of the heart, in which the transverse striae are replaced by granules and globules of fat; characterized by feeble cardiac action, venous stasis and dyspnœa.

**Causes.** Impaired nutrition in the elderly; prolonged anaemia; chronic gout; alcoholism; phosphorus poisoning; cancer; tuberculosis and scrofula; disease of the coronary arteries.

**Pathological Anatomy.** The distinction must be made between a deposit of fatty tissue upon or around the heart, and the degeneration of its muscular tissue.

The fatty metamorphosis may affect the whole organ, or the entire ventricles, or be limited to portions of them. If the degeneration be marked the color is yellowish, the tissues soft and easily torn, and to the touch have a greasy feeling, oil being yielded on pressure.

The microscopic changes are characteristic. The striae of the muscle are easily rendered indistinct by fat and oil globules, gradually becoming more and more obscured, and finally disappearing altogether, the fibres being replaced by fat granules.

**Symptoms.** Those of weak heart, anaemia of organs and venous stasis, to wit: *feeble, irregular, but slow cardiac action, compressible pulse, praecordial distress*, often aggravated by attacks of angina pectoris; *dyspnoea*, aggravated on exertion, with anaemia of the various organs from the feeble propulsive power; if of brain, *vertigo, swooning, or pseudo-epileptic attacks*, especially marked on suddenly rising from a recumbent position; if of lungs, *dry, hacking cough*; if of gastro-intestinal tract, *dyspepsia and constipation*; if of kidneys, *scanty urine, at times albuminous*; and finally, *dropsy*, beginning in the lower extremities.

A formidable symptom, causing much inconvenience as well as alarm to the patient, is what he will term his constant "sighing," the Cheyne-Stokes breathing—"A pause in the breathing, a complete suspension of the respiratory acts for a period of time (during which breathing might occur several times in the normal manner), then the

resumption of respiration very feebly and slowly, and a gradual and progressive increase in the number and depth of respirations until the maximum is reached, and then again a gradual and progressive diminution, in the same order, in the number and depth of the respirations, until another pause occurs"—the "oscillating respiration."

Concomitant symptoms are atheromatous change in the vessels, and the *arcus senilis*.

**Palpation.** Weak cardiac impulse.

**Percussion.** Not markedly changed unless preceded by enlargement of the heart.

**Auscultation.** First sound feeble, toneless, almost inaudible, the second sound being normal, unless changes in the valves are present.

**Diagnosis.** If aged persons, or those exposed to the causes, have feeble heart, associated with atheroma of the vessels and the *arcus senilis*, the diagnosis of fatty heart is almost positive. If dropsy occur, however, it is difficult to distinguish from dilatation of the heart.

**Prognosis.** Incurable, the affection pursuing a more or less chronic course. Life may be prolonged at times by treatment, but death finally results from exhaustion, or suddenly, from cardiac paralysis or rupture of the heart.

**Treatment.** Incurable, there being no plan of treatment that can restore the degenerated muscular fibre. Generous diet, very moderate exercise, *stimulants, oleum morrhuae*, and the "triple elixirs,"—*elixir ferri, quininæ et strychninæ*.

All the excreting organs must be kept active, so as to relieve the crippled heart as much as possible.

To sustain the cardiac action, *caffeina* or *morphina* in small doses, or hypodermically for the so-called cardiac asthma. Digitalis is contra-indicated in advanced cases.

Quain says: " *Galvanism* applied from the back of the neck to the praecordium, by the interrupted current, has been found useful."

## VALVULAR DISEASES OF THE HEART.

**Definition.** Alterations in the cardiac valves or orifices, rendering the former incapable of properly closing the latter, or causing the latter to interrupt the blood current in its normal movement.

The lesions are of two kinds, to wit: *obstructive* and *regurgitant*.

A *regurgitant lesion*, termed also *insufficiency*, is such change in the valves as to permit a portion of the blood to flow backward instead of onward, the true direction of the blood current.

An *obstructive lesion*, termed also *stenosis*, is a narrowing of the orifice, thereby obstructing the passage of the blood.

**Varieties.** I. Mitral regurgitation. II. Aortic regurgitation. III. Tricuspid regurgitation. IV. Pulmonic regurgitation. V. Mitral obstruction. VI. Aortic obstruction. VII. Tricuspid obstruction. VIII. Pulmonic obstruction.

**Causes.** In the young, usually the result of endocarditis, and generally affecting the mitral orifice or valves; in the elderly, chronic endocarditis or atheromatous degeneration, most commonly affecting the aortic orifice or valves.

Prof. Da Costa has clearly established the production of aortic disease in early life by overwork and strain of the heart. Syphilis; dilatation of the heart; atrophy or contraction of the valves, and congenital malformations.

#### MITRAL REGURGITATION.

**Pathological Anatomy.** The most common conditions observed are more or less contraction and narrowing of the tongues of the valves, with irregular thickening and rigidity; atheroma or calcification of the segments; laceration of one or more segments; adhesion of one or more segments to the inner surface of the ventricle; rupture of the *chordæ tendinae*, and also contraction and hardening of the *musculi papillares*.

As a result of the regurgitation of the blood into the left auricle, there is dilated hypertrophy.

**Symptoms.** Insufficiency of the mitral valves soon leads to cardiac hypertrophy, to compensate for the diminished amount of blood sent onward by the ventricular systole. When the "compensation ruptures" there occurs *praecordial distress, cough, dyspnœa, feeble, soft, rapid, irregular pulse*; finally pulmonary congestion, oedematous limbs, the abdominal cavity filled, liver congested, urine scanty and albuminous, the patient dying "drowned in his own fluid."

**Inspection.** Cardiac impulse lower than normal, the heart being enlarged.

**Palpation.** Early, forcible and diffused impulse; later, feeble diffused impulse.

**Percussion.** Transverse and vertical cardiac dullness increased.

**Auscultation.** Systolic blowing or churning murmur, audible in the mitral area, propagated to the apex, left axilla and under the angle of the scapula, either occurring with or taking the place of the *first sound* of the heart; the second sound markedly accentuated.

**Prognosis.** So long as the compensating hypertrophy can be maintained the prognosis is not unfavorable; when dilatation supervenes, however, the patient soon perishes, either from congestion of the lungs or dropsy and exhaustion.

#### AORTIC REGURGITATION.

**Pathological Anatomy.** The valves or segments adhere to the walls of the aorta, or a segment is lacerated or may be perforated, or, more commonly, the segments are shrunken, deformed and rigid, permitting the regurgitation of the blood. These deficiencies in the valves are usually associated with more or less narrowing of the orifices.

The cardiac muscle rapidly hypertrophies, its cavity enlarging—*dilated hypertrophy*.

**Symptoms.** Those of marked hypertrophy, to wit: forcible cardiac action, headache, tinnitus aurium, congestion of the face and eyes, with *pulsating vessels*, even small ones pulsating that before were not visible to the eye; pulsations of the retinal vessels can be recognized with the ophthalmoscope; the *receding pulse*, which is particularly characteristic—forcible impulse but rapidly declining, called “water-hammer” pulse; also, the “Corrigan pulse.”

When “compensation ruptures,” dyspnœa, cough, hepatic enlargement, congestion of the kidneys, with scanty, albuminous urine, ascites and dropsy. If mitral insufficiency is now superadded, general venous stasis and death rapidly occur.

**Inspection.** Forcible cardiac impulse.

**Palpation.** Strong, full cardiac impulse.

**Percussion.** Cardiac dullness increased transversely and vertically.

**Auscultation.** *First sound*, forcible; *second sound*, replaced or associated with a *churning, rushing or blowing murmur* of low pitch, distinct at the second right costal cartilage, but most distinct at the junction of the sternum and the fourth left costal cartilage, transmitted downward toward and below the apex.

**Prognosis.** The one valvular disease most likely to occasion

sudden death; still, so long as the compensating hypertrophy remains intact, compatible with quite an active life.

#### TRICUSPID REGURGITATION.

**Pathological Anatomy.** This form of valvular insufficiency is either associated with right-sided cardiac dilatation from pulmonary obstruction, or is the result of mitral disease.

The tricuspid orifice is dilated in the majority of cases; occasionally the segments of the valves are contracted or adherent to the ventricle.

**Symptoms.** Venous stasis with its various consequences, and especially *pulsation of the jugular*, synchronous with the cardiac movement, and finally general venous pulsation, especially of the liver, pulmonary congestion, engorgement of the kidneys and dropsy. These symptoms are superadded to those of the affections with which tricuspid insufficiency is always associated.

**Inspection.** Diffused, wavy, cardiac impulse; jugular pulsation synchronous with the cardiac movement, uninfluenced by respiration, also more or less prominent hepatic pulsation.

**Palpation.** The cardiac impulse extended, but feeble.

**Percussion.** Dullness on percussion, extending to the right and below the sternum.

**Auscultation.** The first sound is accompanied by a blowing murmur most intense at the junction of the fourth and fifth ribs with the sternum, distinct over the xiphoid appendix, becoming feeble or lost in the left axillary region; often associated, however, with a mitral systolic murmur.

#### PULMONIC REGURGITATION.

**Pathological Anatomy.** Insufficiency of the pulmonary valves is of rare occurrence, but when present the changes correspond more or less with those described for aortic regurgitation.

**Symptoms.** Those of dilatation of the right side of the heart and consequent pulmonary congestion, to wit: dyspnoea, deficient aeration of the blood, and cyanosis, distention of the superficial vessels, palpitation of the heart, praecordial distress, sudden suffocative attacks and dropsy.

**Percussion.** The cardiac dullness extending to the right of the sternum.

**Auscultation.** A loud blowing murmur associated with the second sound of the heart, most distinct at the junction of the third left costal cartilage and the sternum.

**Prognosis.** Death results, sooner or later, from dropsy and exhaustion.

#### MITRAL OBSTRUCTION.

**Pathological Anatomy.** Mitral stenosis is caused by deposits around the orifice, the result of endocarditis, or else the segments of the valves are "glued together by their margins," leaving but a funnel-shaped opening, the so-called "button-hole" mitral valve. Vegetations on the valves lead to more or less obstruction of the blood current.

**Symptoms.** Hypertrophy of the left auricle results from obstruction at the mitral orifice, the symptoms of stenosis being unobservable until the "compensation ruptures," when occur *irregular*, small and *feeble pulse*, *dyspnæa*, *cough*, *bronchorrhœa* the result of bronchial congestion; dilatation of the right side of the heart, soon leading to general venous stasis, dropsy and death.

**Inspection.** Normal until auricular hypertrophy, when an undulatory impulse is observed over the left auricle.

**Palpation.** When cardiac dilatation occurs, a diffused, feeble and irregular cardiac impulse is felt near the xiphoid appendix.

**Auscultation.** First sound normal in character but often irregular in rhythm. The second sound normal. A blowing, sometimes rasping, sound is heard, immediately *after the second sound* of the heart ceases, and immediately *before the first sound begins*—a *presystolic murmur*, heard most distinctly in the mitral area, lessening in intensity toward the cardiac base. The cardiac sounds are all more or less enfeebled if cardiac dilatation occur.

**Prognosis.** The prognosis is controlled by the hypertrophy. Under favorable circumstances mitral stenosis is compatible with a long and rather active life.

#### AORTIC OBSTRUCTION.

**Pathological Anatomy.** Stenosis of the aortic orifice depends upon the projection of the valves inward, and their becoming rigid and thickened, or atheromatous or calcareous, so that they cannot be pressed back by the blood, but remain constantly in the current of

the circulation. Occasionally the valves are covered with fibrinous masses, the opening into the artery being thus more or less completely closed, or the segments may be adherent by their lateral surfaces, leaving a central opening, which may be so contracted as to only permit the passage of the smallest article.

**Symptoms.** Hypertrophy of the left ventricle rapidly supervenes upon aortic stenosis. The *pulse* is small, slow and hard. The supply of blood to the brain is insufficient in many cases, and hence attacks of *vertigo*, *syncope* or slight epileptiform seizures occur; finally, dilatation of the left ventricle and incompetence of the mitral valve result, with subsequent pulmonary congestion, dyspnoea and general venous stasis, the *pulse* soft and feeble.

**Palpation.** Lowered cardiac impulse, strong in the early stage, feeble when dilatation occurs.

**Percussion.** The cardiac dullness is increased vertically, the transverse dullness being slightly affected.

**Auscultation.** The first sound replaced or associated with a *harsh, rasping sound*, whistling at times, having its greatest intensity at the junction of the second right costal cartilage with the sternum, transmitted along the vessels; the murmur may sometimes be heard a short distance from the patient.

Usually aortic stenosis is associated with more or less aortic regurgitation, whence a *double murmur occurs*, having its greatest intensity at the base of the heart, the so-called see-saw murmur.

**Prognosis.** So long as compensation is maintained the symptoms of aortic stenosis are *nil*. When the compensation is ruptured, the usual symptoms of dilatation, venous stasis and dropsy soon follow.

#### TRICUSPID OBSTRUCTION.

This condition is one of the rarest affections of the heart, and if it ever does occur with or following an attack of endocarditis, the anatomical changes are similar to those of mitral obstruction. This condition soon leads to auricular dilatation; venous stasis rapidly supervenes, associated with venous pulsations similar to those described when speaking of tricuspid regurgitation.

#### PULMONIC OBSTRUCTION.

**Pathological Anatomy.** Always a congenital malady, the changes consisting in "constriction of the pulmonary artery, un-

closed foramen ovale, unclosed ductus Botalli, stricture at the ductus Botalli, with hypertrophy of the right cavity and frequent association with tuberculosis of the lungs."

Hypertrophy of the right ventricle may ensue, the walls becoming almost as thick as those upon the left side.

Those in whom these congenital defects in the cardiac structure occur are otherwise weak, develop slowly, have flabby tissues, soft bones and seem poorly nourished.

**Symptoms.** The hypertrophy which often ensues may keep life apparently comfortable for some time, but sooner or later "compensation ruptures," when cough, dyspnoea, cyanosis and death occur.

**Prognosis.** The duration of these congenital affections is short, usually from a few days to a few months; although several well authenticated cases record a much longer duration.

#### DIAGNOSIS OF VALVULAR DISEASES.

In making a differential diagnosis between the various forms of valvular diseases of the heart, strict attention must be paid to the points of greatest intensity at which the several murmurs are heard.

A murmur occurring with or taking the place of the *first sound* of the heart—the ventricular systole—heard most distinctly at the apex, transmitted to the left axilla, and to the inferior angle of the scapula, signifies mitral regurgitation—a *mitral systolic murmur*.

A murmur occurring with or taking the place of the *first sound* of the heart, with its point of greatest intensity at the xiphoid appendix, signifies regurgitation at the tricuspid orifice—*tricuspid systolic murmur*.

A murmur heard with the *first sound* of the heart, high-pitched, rasping or grating in character, with its point of intensity greatest at the second right costal cartilage, signifies obstruction at the aortic orifice—an *aortic systolic murmur*.

A murmur heard with the *first sound* of the heart, soft in character, with its point of intensity most distinct at the junction of the third left costal cartilage with the sternum, signifies obstruction at the pulmonic orifice—a *pulmonic systolic murmur*.

A murmur occurring immediately after the *second sound* of the heart, and immediately before the beginning of the *first sound* of the heart signifies obstruction at the mitral orifice—a *presystolic mitral murmur*.

A murmur heard with or taking the place of the *second sound* of the

heart, most distinct at the second costal cartilage, to the right of the sternum, and well transmitted toward the apex or below, signifies insufficiency or regurgitation at the aortic orifice—an *aortic regurgitant or diastolic murmur*.

Although eight distinct valvular murmurs have been described as occurring in the heart, those on the right side are of rare occurrence, and hence of little clinical importance.

If a *murmur* be heard with the *first sound* of the heart, it is almost certainly *aortic obstructive* or *mitral regurgitant*; and if heard with the *second sound*, it is probably *aortic regurgitant*. A *presystolic mitral murmur* is also of comparatively rare occurrence, the force with which the blood passes from the left auricle into the left ventricle being, under ordinary circumstances, insufficient to excite sonorous vibrations.

*Functional* or *anæmic murmurs* may be confounded with the various forms of valvular disease of the heart. The chief points of distinction between them are, that an *anæmic murmur*, which is always heard at the base of the heart, is always systolic in time, not transmitted away from the heart, and is soft in character, low in pitch, and of variable intensity, now being heard, now entirely absent.

**Treatment.** There is no special plan of treatment for each form of valvular disease. Prof. DaCosta says, "I hold that the precise valve affected is not, with our present resources, the keynote to the treatment of valvular heart disease. We are to take as indications: 1. The state of the heart-muscle and of the cavities. 2. The rhythm of the heart-action. 3. The condition of the arteries and veins and of the capillary system. 4. The probable length of existence of the malady, and its likely cause. 5. The general health. 6. The secondary results of the cardiac affection."

The important point to bear in mind in the treatment of valvular disease of the heart is that it is associated either with *cardiac hypertrophy* or *dilatation*, and the treatment, if any at all be required, is directed toward this secondary condition. If compensation be complete, attention to the condition of the bowels, kidneys and digestion, with some general directions as to exercise, is all that is required.

If the hypertrophy become marked and excessive, it is best controlled by either *aconitum*, *veratrum viride*, or *nitro-glycerin*.

If dilatation have occurred, the heart weak and feeble, the circulation impeded, and venous stasis has followed, *digitalis*, *strophanthus*, or *sparteine sulphate*, with more or less active purgation, is indicated.

If fatty degeneration of the heart result, the indications are for cardiac rest, stimulants, *strophanthus* and attention to the excretions.

If the cardiac rhythm is disturbed, add *belladonna* to whatever other plan of treatment is being used.

If the capillary circulation is weak, *strophanthus* and *nitro-glycerin* (*glonoinum*) act better than digitalis, which has the power of contracting the arterioles.

Any of the secondary results of the valvular affection are to be treated according to the particular indications.

## PALPITATION OF THE HEART.

**Synonym.** Irritable heart.

**Definition.** A functional disturbance of the heart; characterized by increasing frequency of its movements and more or less irregularity of the rhythm, with a strong tendency toward hypertrophy.

**Causes.** Over-exertion, "the heart strain" of Da Costa; dyspepsia; uterine diseases; excesses in tea, coffee, tobacco, alcohol or venery; moral and emotional causes, grief, anxiety and fear.

**Symptoms.** Usually palpitation of the heart has a sudden onset after some one of the causes mentioned, *praecordial oppression or pain, rapid, tumultuous beating*, the impulse being visible through the patient's clothing, *dyspnœa, anxiety*, and a sense of *choking or fullness in the throat*, the recumbent position impossible, *vertigo, faintness, flashes of light*, the pulse full and strong or feeble, the *face flushed or pale*, the patient having a feeling of anxiety with a sense of *impending danger* and a fear of sudden death. These attacks are paroxysmal, lasting from a few moments to several hours, or a day, the patient often voiding a large quantity of limpid urine after the paroxysm has subsided, when there is a strong tendency to sleep.

**Diagnosis.** Irritability of the heart is differentiated from the various forms of cardiac disease by the absence of all the physical signs mentioned as occurring in those conditions.

**Prognosis.** If early and properly treated, favorable.

**Treatment.** The first point in the treatment of irritability of the heart is to remove the cause; the next, to prevent the recurrence of the attacks of palpitation.

The majority of cases do well by a combination of *digitalis* and

*belladonna*. Permanent relief is often afforded by a combination of *potassii bromidum* and *veratrum viride*. *Chloral* is also useful. If the patient be anaemic, the author has had excellent results follow the prolonged use of the *elixir ferri, quinine et strychnine*. Locally, *emplastrum belladonnae* to the praecordium affords relief.

### ANGINA PECTORIS.

**Synonym.** Neuralgia of the heart.

**Definition.** Paroxysms in which there occur sharp cardiac pains, extending usually into the left shoulder and down the left arm, accompanied by a feeling of constriction of the thorax and a strong sense of impending death.

**Causes.** Depending upon the variety, whether nervous origin or organic. Often hereditary; associated with chronic cardiac changes, as diseases of the coronary arteries or calcification of the valves; the excessive use of tobacco; according to Rousseau, it is a form of masked epilepsy, and may alternate with true epileptic attacks; often associated with hysteria.

**Pathological Anatomy.** *Nervous form*, "the pathological changes which stand in a causative relation to the attacks are those of the cardiac plexus of the phrenic and of the pneumogastric nerves. Pressure of enlarged lymphatics, inflammation of parts of the cardiac plexus, with changes in the coronary artery, seem to be most constant."

*Organic form*, a disease of the arteries, ossification and occasionally obliteration of the cardiac arteries, producing cardiac ischæmia.

**Symptoms.** A paroxysmal affection, the attacks occurring irregularly; in the interval entire absence of symptoms.

"The patient suddenly sits up in his bed; with a cry of horror indicates the sense of pain at the praecordium. This pain is of great intensity, but is of a cold and sickening character; the chest is fixed, the breathing quickened, and the hand placed over the epigastrium finds that the heart's action is slight and enfeebled. The face wears a look of horror, pale and slightly leadened; a cold sweat breaks out upon the forehead; worse than the pain is the feeling of fearful sickness and depression. The poor patient gasps, 'I shall die! I shall die!' and sometimes his short but concentrated sufferings in a few moments end in death."

The unpleasant sensations of these patients during an attack, and the nervous disorder associated with it, slowly bring about a mental change. They are depressed and gloomy, sometimes suicidal, often developing epilepsy.

**Diagnosis.** The points to be remembered are that the attacks are always paroxysmal, the patient having a sense of coldness, and frequently a cold sweat, the heart's action not increased, the chest fixed and the breathing slow.

**Prognosis.** Unfavorable, the patient, sooner or later, either succumbing during a paroxysm or from exhaustion, the result of the cardiac changes.

**Treatment.** During the intervals between the attacks, an attempt should be made to remove the exciting cause or diminish its predisposing power.

For the organic form, no one remedy is comparable with a long course of *potassii iodidi*, gr. x-xx, three times daily, as the frequency and intensity of the attacks are diminished and a fair number of cases are cured, proving the axiom, "the iodides are the digitalis of the arteries."

For the nervous form, all violent emotions and active physical exercise is to be avoided, the diet regulated and the excretions watched. Among the drugs that are useful are *ferrum*, *arsenicum*, *strychnina*, *phosphorus* and *zincum*. If the cardiac action be weak, use *strophanthus*. Trousseau urges the administration of *belladonna* in continuous small doses, on the ground of the analogy of the affection to epilepsy. Quain states that a continuous current, the positive pole on the sternum and the negative pole on the lower vertebrae, lessens the severity and frequency of the anginal paroxysms.

For the attack, prompt relief follows the use of *amyl nitris*, mijj, inhaled at the instant, or *morphinæ sulphas*, gr.  $\frac{1}{6}$ - $\frac{1}{4}$ , to which may be added with advantage *atropinæ sulphas*, gr.  $\frac{1}{20}$ , hypodermically, or *nitro-glycerin*, gr.  $\frac{1}{100}$ - $\frac{1}{75}$ - $\frac{1}{50}$ , every three or four or five hours. In many cases the use of gr.  $\frac{1}{200}$  of this powerful drug, three or four times a day for a long time, lessens not only the frequency but the severity of the paroxysms.

## DISEASES OF THE NERVOUS SYSTEM.

### CONGESTION OF THE BRAIN.

**Synonyms.** Cerebral hyperæmia ; cerebral congestion.

**Definition.** An abnormal fullness of the vessels (capillaries) of the brain ; *active*, when arterial fullness ; *passive*, when venous fullness ; characterized by headache, vertigo, disorders of the special senses, and if the hyperæmia be decided, convulsions.

**Causes.** *Active.* Increased cardiac action, the result of hypertrophy of the left ventricle ; general plethora ; excesses in eating and drinking ; alcoholism ; sunstroke ; prolonged mental labor ; diminished amount of arterial blood in other parts, the result of the compression of the abdominal aorta ; ligation of a large artery, and the suppression of an habitual bleeding hemorrhoid are examples.

*Passive.* Dilatation of the right heart ; pressure upon the veins returning the cerebral blood.

**Pathological Anatomy.** The *post-mortem* appearances are, overloading of the venous sinuses and of the meningeal vessels, including the finer branches ; the *pia mater* appears vascular and opaque ; the *gray matter* of the convolutions unduly red ; the *convolutions* may be compressed and the *ventricles* contracted, with the displacement of a corresponding amount of cerebro-spinal fluid.

Long-continued or repeated congestions lead to enlargement and tortuosity of all the vessels, a moist and slimy condition (*œdema*) of the cerebral substance, and an increase in the sub-arachnoid fluid.

**Symptoms.** "Rush of blood to the head" may be gradual or sudden in its onset, the symptoms aggravated by the recumbent position. *Headache*, with paroxysmal neuralgic darts, *disorders of vision and hearing*, buzzing in the ears and sparks before the eyes, contracted pupils, *vertigo*, *blunted intellect*, inability to concentrate the mind, *irritable temper* and curious *hallucinations*. The *face* is *red*, the *eyes congested*, and the *carotids pulsating*. The *sleep* is disturbed by *dreams* and *jerkings of the limbs*. If the attack be sudden (apoplectiform), *sudden unconsciousness* with *muscular relaxation* occur.

Cerebral hyperæmia in children often presents alarming symptoms,

such as great restlessness, insomnia, night terrors, gnashing of the teeth during sleep, vomiting, contraction of pupils followed by general convulsions. Any or all of these symptoms may continue more or less marked from an hour or two to a day, the child enjoying its usual health after a sound sleep, save some fatigue.

**Prognosis.** *Mild cases* terminate favorably in a few hours to a day or two, but show a strong tendency to recur. *Severe cases* (apoplectiform) may terminate in health, but usually foretell cerebral hemorrhage.

The *passive form* is controlled by the lesions giving rise to it.

**Treatment.** *Active form.* Remove the cause if possible. *Elevate the head* and apply *cold*, either cold cloths or the ice cap, at the same time warmth to the feet. *Leeches* to the mastoid, or *cups* to the neck, or in the *apoplectiform* variety *venesection*, to diminish the intercranial blood pressure; compression of the carotids, or ligatures about the thighs, have been recommended.

An active purgative or an enemata of water and vinegar is also indicated, to lessen the vascular tension.

In mild cases the application of *cold* and *potassii bromidum*, gr. xxx-xl, repeated, controls the congestion; *extractum ergotæ fluidum* is often beneficial; in more severe cases any or all of the above-mentioned means, together with full doses of *tinctura veratri viridis* or *tinctura aconiti*, may be needed.

*Passive form.* Becomes a part of the treatment producing the hyperæmia.

## CEREBRAL ANÆMIA.

**Definition.** An abnormal decrease in the quantity of blood in the cerebral vessels; *general*, when the diminished supply includes all the vessels; *partial*, when the diminished supply is limited in area; characterized by pallor, headache, vertigo, some loss of power, and, rarely, convulsions.

**Causes.** *Partial* cerebral anæmia results from obstruction of a vessel, from embolism or thrombosis. *General* cerebral anæmia results from hemorrhages, wasting diseases, during convalescence from severe attacks of fevers, sudden shock, feeble cardiac action and general anæmia.

**Pathological Anatomy.** The cerebral vessels contain less blood than normal; the brain is pale and milky in color, and on

transverse section there are no bloody points; the ventricles and perivascular lymph spaces are well filled with fluid.

In *partial* anæmia the local conditions differ somewhat from the above.

**Symptoms.** *General anæmia*: headache, relieved by the recumbent position; *vertigo*, aggravated by exertion; general *pallor* and anæmia, with attacks of *fainting*; when the general cerebral anæmia is sudden and decided, convulsions occur.

*Partial anæmia*; sudden loss of power, of a limited muscular area, gradually returning to the normal condition.

**Prognosis.** Favorable in all cases save those the result of severe and repeated hemorrhages.

**Treatment.** Regulated *nourishment*, with *stimulants*. A certain number of hours daily in the recumbent position is of advantage. When a tendency to attacks or *swooning* exists, stimulants or even the cautious inhalation of *amyl nitris* are indicated. To improve the quantity or quality of the blood—

R.	Tinct. ferri chlor., . . . . .	m <sub>xv</sub>	
	Acid. phosph. dil., . . . . .	m <sub>v</sub>	
	Liq. arsenici chloridi, . . . . .	m <sub>ijj</sub>	
	Syr. limonis, . . . . .	m <sub>xx</sub>	
	Syr. zingiberis, . . . . . q. s. ad .	3 ij.	M.

SIG.—Every six hours, well diluted.

Or—

R.	Extracti erythroxyli cocoæ fld., . . . . .	f <sub>3</sub> ss	
	Vini albi fort., . . . . .	f <sub>3</sub> ss.	M.

SIG.—One hour after meals.

## CEREBRAL THROMBOSIS AND EMBOLISM.

**Synonymis.** Partial cerebral anæmia; occlusion of cerebral vessels; cerebral apoplexy (?).

**Definition.** The occlusion of a cerebral vessel, from the formation of a *thrombus*, or the presence of an *embolus*, thus causing anæmia of some portion of the brain; characterized by the gradual—when the result of thrombosis, and the sudden, when due to embolism—development of headache, vertigo, disorders of intelligence, with more or less complete insensibility and paralysis.

**Causes.** *Thrombosis*, or the formation of a clot in the vessel—an *ante-mortem* coagulation—is almost always the result of chronic

endarteritis, as seen in the aged, together with a slowing and weakening of the blood current. Chronic alcoholism and syphilis are the usual causes of cases occurring in young adults.

*Emboli*, in the great majority of cases, results from an endocarditis—cardiac emboli; small particles of the exudation are carried into the circulation and are deposited in the brain. Emboli may also be derived from aortic aneurism, or syphilitic of the great vessels.

**Pathological Anatomy.** The cerebral arteries may be obstructed by emboli or thrombi; the cerebral veins and sinuses by thrombi only. The changes in the cerebral tissue are those of anaemia of the part or parts supplied by the occluded vessels. The subsequent changes depend upon the anatomy of the vessels. If the obstructed artery has anastomoses, the collateral circulation is soon established and the brain tissue assumes its normal condition. If, on the other hand, the occluded vessel be one of "Cohnheim's terminal arteries"—arteries without anastomoses—the blood in the whole extent of the occluded vessel coagulates, thus preventing the backward flow of blood from the surrounding capillaries and so obstructing collateral circulation, whence the anaemic tissue dies or undergoes *necrobiosis*, followed by yellowish-white softening; or, if the vessel beyond the seat of the occlusion remains pervious, blood flows back through the capillaries from the nearest artery or vein; the parts that a short time before were bloodless now become deeply engorged, the succeeding changes in the vessels permitting *diapedesis* of the red blood globules; the tissues which are undergoing disintegration are colored by the red globules, causing the appearances entitled "red softening," which after some weeks becomes "yellow softening," finally changing to "white softening," when there is a milky, or rather creamy, fluid mixed with masses or particles of broken-down nerve elements.

The vessel most commonly occluded is the *left middle cerebral artery*, which sends branches to the second and third frontal convolutions, the anterior and superior portions of the three temporal convolutions, the island of Reil, the parietal convolutions, part of the external and all of the internal capsule, the lenticular nucleus, and most of the *corpus striatum*,—the *motor centres*.

**Symptoms.** Two distinct modes of onset; gradual, when the result of thrombosis; sudden or apoplectic, when due to embolism.

*Cerebral thrombosis.* Most common in the aged. Persistent headache and vertigo, at one time severe and at another mild. Next,

alterations of the patient's character; *irritable, morose and despondent*, with periods of *absent-mindedness, disorders of vision, and impairment of memory, speech becoming hesitating and mumbling*. *Impaired locomotion*, the result of the vertigo, and of *muscular weakness and trembling*, followed sooner or later by *hemiplegia*, which may be preceded by sudden insensibility or occur gradually, the symptoms slowly proceeding to *senile dementia* and death from exhaustion; or rarely, the symptoms are not so grave, and partial or complete recovery occurs after the hemiplegia, from establishment of the "collateral circulation."

*Cerebral embolism.* The symptoms are sudden, but either mild or grave in character.

*Mild variety;* sudden and severe *vertigo, confusion of mind, muscular twitchings*, usually one-sided, and *vomiting*, followed by *hemiplegia*, most frequently of the right side, the intellect clear but hesitating. After some weeks or months the paralysis usually disappears and recovery is complete.

*Grave or apoplectic variety.* *Sudden headache, vertigo, flushing or pallor of the face*, or the patient may utter a *sharp cry*, fall to the ground with *sudden unconsciousness and complete muscular resolution*, followed by death, or a gradual return of consciousness with *hemiplegia*, which is generally right-sided, remaining for several weeks or months, or is persistent, the *mind remaining normal or enfeebled* and the *emotional nature highly excitable* and the *reason and judgment clouded*, continuing thus for years, or gradually developing into *dementia, exhaustion and death*.

*Duration.* *Thrombosis*, essentially an affection of the elderly, has a chronic course. Months or years may be occupied with the various symptoms until the phenomena of *senile dementia* develop.

*Embolism* is of sudden onset, and may be followed by a rapid recovery.

*Diagnosis.* Thrombosis is associated with changes in the vessels, the *arcus senilis* and other evidences of *senile degeneration*.

Embolism may be mistaken for cerebral apoplexy, and while a positive differentiation cannot always be made, the chief points will be considered when discussing that affection.

*Prognosis.* Thrombosis is a permanent and progressive condition in the majority of instances. Recovery is a rare termination.

Embolism may be followed by a perfect recovery. Usually, how-

ever, some evidences of the plugging remain permanently. Death may be the result within a day or two, from the plugging of a large vessel, the patient never emerging from the coma. In other cases the patient arouses from the coma, the hemiplegia with aphasia persisting, and the case pursues the usual course of localized cerebral softening.

**Treatment.** The indications in the early stage of embolism and thrombosis is the reëstablishment of the circulation within the district deprived of blood-supply, in order to prevent the changes incident to defective nutrition; this is accomplished by means to strengthen the heart's action, tonics, perfect rest for some time after the attack, a plain but nutritious diet, and attention to the various excreta.

Prof. Bartholow "has had remarkable results from the following plan of treatment in thrombosis:" *Ammonii carbonas*, gr. x, with *ammonii iodidi*, gr. v, three times a day, continued for several months, "the object being dual—to increase the action of the heart and arteries and to effect a solution of thrombi forming by maintaining the alkalinity of the blood."

In the aged, presenting indications of degeneration, much benefit results from the use of—

R. Liquor potassii arsenitis, . . . . .	m <i>jij-v</i>
Syr. calcii lacto-phosphat., . . . . .	3 <i>j-ij.</i> M.

SIG.—After meals.

It may be combined with *oleum morrhuae* with decided advantage.

For *embolism*, the immediate and persistent use of the following may dissolve the plug:—

R. Ammonii carbonat., . . . . .	gr. v
Liquor ammonii acetatis, . . . . .	f <i>3j.</i> M.

SIG.—Three or four times daily.

"In a month or two a very light galvanic current (from two cups) may be passed through the brain in both directions." (Bartholow.)

## CEREBRAL HEMORRHAGE.

**Synonym.** Apoplexy.

**Definition.** The sudden rupture of a cerebral vessel and escape of blood into the cerebral tissue, causing pressure and more or less destruction of the brain substance; characterized by sudden unconsciousness, irregular, noisy respiration and complete muscular relaxation.

**Causes.** Rare under forty years of age. The principal cause is disease of the vessels—a periarteritis, resulting in miliary aneurisms, and especially if associated with cardiac hypertrophy; hereditary tendency; Bright's disease; syphilis; gout. More frequent in the spring and autumn.

**Pathological Anatomy.** The most common locations of cerebral hemorrhage are the *corpus striatum* and *thalamus opticus*; less common the *anterior* and *middle lobes* and the *cerebellum*; next in frequency the *pons* and *medulla oblongata*; and rarely on the *convexity* of the brain, termed *meningeal hemorrhage*.

When the hemorrhage is large, the blood may break into the ventricles and pass by the *iter* from the third to the fourth ventricle.

A recent clot is dark in color, and in consistency a soft, grumous mass, composed of coagulated blood and brain substance in varying proportions, at whose centre is the opening into the ruptured vessel. The *clot* excites inflammation around it, resulting in its being encysted, by the development of new connective tissue from the neuroglia, and then gradually absorbed, leaving a cicatrix, or the brain tissue around the clot softens and degenerates—localized softening.

**Symptoms.** Two modes of onset, to wit: with and without *prodromes* or "warnings."

**Prodromes.** Headache, vertigo, transient deafness or blindness, sensations of numbness of the extremities, with local palsies, together with the constant *dread of an attack*.

The *attack* begins with *vomiting*, followed by either partial or complete *insensibility*; *respiration slow, irregular and noisy*; during the inspiration the paralyzed cheek is drawn in, and puffed out in expiration; *pulse slow and full*; *pupils uninfluenced by light*, the *face flushed*, the *eyes congested* and the *carotids throbbing*; the *temperature declines below the norm*, a degree or two.

The *muscular system* is profoundly relaxed, and the *reflex movements* are abolished. The head and eyes *deviate*, in many cases, *toward the affected side in the brain or from the paralyzed side*.

If the unconsciousness continues longer than twenty-four hours, death is the usual termination, preceded by pale face, irregular and rapid pulse and respiration, and rise of temperature.

*Reaction* obtains in from a half to three hours, consciousness returning, reflex excitability reviving, associated with headache, con-

fusion of mind, and more or less *paralysis* of motion and sensibility of one side of the body termed—*hemiplegia*.

The *electro-excitability* of the paralyzed parts is preserved.

Restoration may be delayed by inflammatory symptoms, the temperature rising to 101°–104° F., with tonic contractions (*early rigidity*) of the paralyzed muscles and severe neuralgic pains.

**Sequelæ.** *Paralysis* of the muscles of the face, tongue, body and extremities of one side, *opposite* to the location of the hemorrhage, termed *unilateral paralysis* or *right* or *left hemiplegia*.

*Paralysis* of both sides of the body, due to simultaneous hemorrhage on both sides, termed *bilateral hemiplegia*.

*Paralysis* of one side of the face and the extremities of the opposite side, due to hemorrhage into the *pons varolii*, termed *alternating* or *crossed paralysis*.

Occasionally *tonic contractions* occur in muscles long paralyzed, termed *late rigidity*, and is evidence of a *secondary degeneration* of the nerve fibres.

*Choreic movements* in paralyzed muscles are termed *post-hemiplegic chorea*, due, according to Charcot, to changes in the motor centres.

The *mental powers* are always more or less permanently impaired, the patient irritable and emotional, and the same holds good concerning the *memory*.

**Diagnosis.** *Insensibility from drink* differs from apoplexy in the following points, to wit: insensibility is not so complete, no drawing in and puffing out of one cheek with respiration, the pulse frequent instead of slow, the pupils influenced by light; upon raising both legs no difference is apparent on allowing them to drop; the eyes and head are not turned to one side, and lastly, the condition is ameliorated on the inhalation of ammonia. I have satisfactorily used Dr. von Wedekind's test for temulence, to wit: "By simply pressing on the supra-orbital notches with a steadily increasing force you may, with certainty of success, bring an unconscious alcoholic to his senses, and thus differentiate between alcoholic and other comas."

*Opium poisoning* differs from apoplexy by the gradual approach of the coma, and that the patient can be momentarily aroused, and also by the absence of the heavy stertor of apoplexy.

*Uræmia* causes a coma that closely resembles apoplexy. A history

of Bright's disease at once clears up the case ; again, uræmic coma is always preceded by convulsions, and has a continued depressed temperature.

*Cerebral embolism* cannot always be differentiated from apoplexy. We may suspect cerebral plugging, if the patient be young ; if he be laboring under acute, subacute or chronic valvular trouble ; if, within brief periods, several incomplete attacks have occurred before a complete comatose condition obtains ; or, if hemiplegia results with passing or slight unconsciousness ; or, if the phenomena are sooner or later followed by cerebral softening, as embolism and thrombosis are the most common causes of softening.

*Syncope* or a fainting-fit is of sudden onset, but being due to a failure of the circulation, the pulse is feeble, the face pale, the respiration quiet, and the duration of unconsciousness short, all the very opposite of an apoplectic attack.

**Prognosis.** If the patient survive the immediate effects of a cerebral hemorrhage, he is always in danger of a new attack, since the causes of the original attack still remain. Another attack or two is the usual course, a fatal termination ultimately occurring.

The *hemiplegia* is uncertain ; a partial recovery may occur within a few months, or it may continue for years.

**Treatment.** If there are prodromal indications, the most prompt means of reducing the intra-cranial blood pressure is by *venesection*, followed by a brisk purgative ; if the patient be weak, however, *leeches* to the mastoid, and *potassii bromidum*, gr. xl-lx, or *extractum ergotæ fluidum*, f $\ddot{z}$ ss-j, may be substituted.

For the attack, loosen clothing, elevate the head, remove constrictions, place in a cool room, have perfect quiet, placing the patient sufficiently on his side, with the face somewhat downward, for the tongue and palate and secretions to fall forward instead of backward into the pharynx, and at once *venesection*, *cold to head*, a mustard foot bath, and *oleum tiglii*, gtt. j-iiij, with *glycerinum*, gtt. xv, placed on back of tongue ; if the pulse be full and strong, when consciousness is regained, either *tinctura veratri viride* or *tinctura aconiti* is indicated.

If during the attack the *face* be *pallid* and the *pulse* *irregular*, the patient is prostrated by the *shock* and *stimulants* and *digitalis* are indicated, with, perhaps, *leeches* to the mastoid and an *enema* of *terebinthina*.

For the secondary fever, either *tinctura aconiti* or *tinctura veratri viride*; for the headache and delirium, *camphoræ bromidum*.

For promoting the absorption of the clot, keep the secretions active a good diet and a course of *potassii iodidum* or *hydrargyri chloridum corrosivum*, alternated with—

R. Liq. potassii arsenit., . . . . . gr. v.  
Syr. calcii lacto-phosph., . . . . . f 3 ij.

Three times a day.

After two or three months a weak *galvanic current* applied directly to the brain, by placing an electrode on each mastoid process, promotes absorption.

For the paralyzed muscles, the faradic current applied by placing one electrode over or near the nerve innervating the muscle and the other over its belly, acts as a tonic, preventing wasting; it is assisted by hypodermic injections of *strychninæ sulph.*, gr.  $\frac{1}{20}$ , three times a week.

## ACUTE MENINGITIS.

**Synonyms.** Cerebral fever; arachnitis.

**Definition.** An acute inflammation of the cerebral *pia mater* and *arachnoid membranes*; characterized by headache, chill, fever, delirium, and followed by symptoms of general collapse.

**Causes.** Cerebral overwork; prolonged wakefulness; acute alcoholism; exposure to the sun; disease of the internal ear; erysipelas; secondary to diseases of serous membranes, and the continued and eruptive fevers. Most frequent in early adult life and in young children, and in males rather than females.

**Pathological Anatomy.** The inflammatory changes may be limited either to the *convexity* or to the *base* of the brain.

Intense *hyperæmia* of both membranes, followed by a purulent and fibrinous *exudation*. The ventricles may be filled with fluid, compressing and flattening the convolutions.

**Symptoms.** Vary according to the stages:—

*Prodromes; headache, vertigo, cerebral vomiting, more or less feverishness, continuing from a few hours to one or two days, when occurs the*

*Stage of Invasion*; onset sudden, with chill, high fever,  $103^{\circ}$ - $104^{\circ}$ , pulse 100-120, face flushed, with congested eyes, headache, ringing in

the ears, *photophobia*, *vertigo*, the *nausea* aggravated, and *projectile vomiting*.

*Stage of Excitation*; general sensibility of the body increased, sensitiveness to light, and acuteness of hearing, *delirium* furious, often resembling insanity, continual *jerking of the limbs*, oscillations of the eyeballs, twitching of the muscles of the face, followed by powerful contractions of the flexor muscles, even to the extent of opisthotonus, and in children convulsions. Duration, from one day to a week or two.

*Stage of Depression or Collapse*; the patient gradually becomes more quiet; the delirium subsides, as well as the muscular agitation; *sonnolence* occurs, passing into *coma*, at times temporary consciousness, coma soon following again; *pulse* irregular and slow, *fever* less; *various palsies*, to wit: strabismus, ptosis, pupils uninfluenced by light, mouth drawn to one side, urine and faeces involuntarily discharged. Death following, either by convulsions or by deepening coma.

**Diagnosis.** *Cerebro-spinal fever* closely resembles acute meningitis, the points of distinction between which are the first named occurring epidemically, associated with marked spinal symptoms and an eruption.

The cerebral symptoms of rheumatism are differentiated from idiopathic meningitis by the association of the joint trouble.

*Cerebral symptoms* of typhoid and typhus fever have a close resemblance to idiopathic meningitis, and are only determined by a study of the clinical history.

In *acute uræmia* the face is turgid, with puffiness of the eyelids; in meningitis the face is pale and no oedema; uræmia has decided albuminuria; it is slight or absent in meningitis; meningitis has chills followed by fever; uræmia has not.

In *delirium tremens* the delirium is a busy one, the patient imagining persons and animals around him, and is wild in his gestures and utterances; the temperature is normal or subnormal, the skin wet and clammy. In meningitis the delirium is mild but incoherent, the surface is hot and dry, and there is severe vomiting and headache.

**Prognosis.** Not very favorable. If recognized early and treated, a fair number of recoveries occur, but it usually leaves the patient subject to attacks of epilepsy or with a persistent headache.

**Treatment.** Must be prompt and energetic from the onset.

At once, active purgation by *oleum tiglii*, gtt. ij, *glycerinum*, m.v,

dropped on the tongue; and if the urinary secretion be scanty, *dry cups* or *digitalis poultices* over the kidneys.

In vigorous subjects a copious *venesection* or *leeches* applied behind the ears, to the temples, or the nuchal region, followed by the application of *cold* to the head, and that it may be thoroughly applied, the head should be shaven.

Control the active circulation by *aconitum* in full doses, frequently repeated, combined with *potassii bromidum*, gr. xx-xl, or use *extractum ergotae fluidum*, f<sub>3</sub> ss-j every few hours. The cerebral circulation may be markedly influenced by compression of the carotids.

The apartment should be cool, the air pure, the patient's head elevated. The diet should be nutritious but easy of assimilation.

The secretions must be carefully watched, the catheter being frequently used in the stage of collapse.

If the case show a disposition to linger, small doses of *hydrargyri chloridum mite* or *potassii iodidum* are of benefit.

Third stage: Free *stimulation*, nutritious food, *ferri iodidum* and flying *blisters*.

## PACHYMENTINGITIS.

**Synonyms.** Meningitis; haematoma of the dura mater.

**Definition.** Inflammation of the *dura mater*; when the external layer is primarily involved it is termed *pachymeningitis externa*; when the internal layer is primarily involved it is termed *pachymeningitis interna*.

**Causes.** *Pachymeningitis externa* is a surgical malady, excited by fractures, penetrating wounds, and other injuries of the skull.

*Pachymeningitis interna* is due to blows upon the head without injury to the skull. A predisposition may be created by chronic alcoholism, scurvy, Bright's disease and syphilis. Chronic internal otitis and suppurative inflammation of the orbit may cause it, also inflammation in the venous sinuses the result of a thrombus undergoing suppurative changes.

**Pathological Anatomy.** *Pachymeningitis interna.* Hyperæmia of the membrane, followed by an exudation which develops into a membranous new formation, containing a great number of vessels of considerable size but having very thin walls. Hemorrhages from these new vessels are of frequent occurrence, which increase the size and thickness of the neo-membrane.

The usual position of the neo-membrane or new formation is on the upper surface of the hemispheres, extending downward toward the occipital lobe. The changes in the adjacent portion of the brain are dependent on the size and thickness of the neo-membrane. Bartholow observed a case in which the "cyst" was half an inch in thickness at its thickest part, and it depressed the hemisphere correspondingly, the convolutions being flattened, the sulci almost obliterated, and the ventricle lessened one-half in size.

In Pachymeningitis syphilitica, the pathological lesion is in the form of gummatous tumors or masses which may degenerate and become either cheesy masses or be converted into a purulent-looking fluid.

In old age the dura mater becomes thick, cartilaginous and of a dull white color. The sheaths of the arteries are also thickened.

**Symptoms.** Very obscure; principally those of cerebral pressure. Cases of persistent *headache*, *vertigo*, *photophobia*, *anorexia*, *insomnia*, gradual *impairment of intellect* and *locomotion*, followed by *delirium*, and *convulsions* and *coma*, or by *apoplectic attacks* and *paralysis*; in the aged, or those in whom some one of the causes of the affection are present, an inflammation of the dura mater may be suspected.

Circumscribed painful *œdema* behind the ear and less fullness of the jugular of the corresponding side, the *phlegmasia alba dolens en miniature* of Griesinger, are indicative of thrombosis in the transverse sinus, as was first shown by Virchow.

**Diagnosis.** Always problematical, as the symptoms are masked and so obscure that a positive diagnosis is impossible.

**Prognosis.** Most unfavorable for either forms, although the course of the malady is usually slow. Surgical treatment in traumatic cases offers some hope.

**Treatment.** Pachymeningitis externa is to be treated surgically. Trephining is indicated in some cases. It is claimed that benefit has followed a thorough course of *potassii iodidum*. In the great majority of cases, however, all that can be done is to treat symptoms.

## TUBERCULAR MENINGITIS.

**Synonyms.** Basilar meningitis; acute hydrocephalus.

**Definition.** An inflammation of the membrane of the brain, more particularly the basal pia mater, attended with or due to the deposit of gray miliary tubercle; characterized by gradual decline of the bodily and mental powers.

**Causes.** Most frequently occurs in children between two and six years of age, although numerous cases are reported occurring between the ages of twenty and thirty years; scrofulous diathesis; inherited diathesis. The "gelatinous children of albuminous parents," as the phrase goes, possess a special susceptibility to tubercular meningitis.

**Pathological Anatomy.** The deposition of tubercle usually occurs at the base of the brain.

Depositions of grayish-white granules, of a translucent, somewhat gelatinous appearance—miliary tubercle, are distributed along the vessels of the pia mater, resulting in inflammation and the exudation of lymph, with the consequent thickening and opacity of the membranes.

The cerebral tissue is not usually involved, although on section the lines indicative of blood vessels are very much increased in number. The ventricles are distended by a clear, or milky, or even bloody serum.

Tubercular deposits occur in the lungs, intestines, and, at times, in other organs.

The presence of the tubercles alone may give rise to no symptoms until the exudative products of the resultant inflammation develop.

**Symptoms.** The advent is either gradual and insidious, or with convulsions, in which cases the after progress is rapid.

*Prodromes:* the child grows irritable, with loss of appetite, loss of flesh, swollen abdomen, constipation alternating with diarrhoea, irregular attacks of feverishness, with attacks of grinding its teeth during sleep or sleeplessness. *Headache* occurs, as shown by the child, even when at play, suddenly stopping and resting its head on its hand or on the floor. Duration of this stage is from one week to a month or two.

*Stage of excitation:* the onset is rather sudden, with obstinate vomiting, severe headache, convulsions, fever,  $102^{\circ}$ – $103^{\circ}$  in the evening, falling to  $99^{\circ}$  in the morning, pulse soft and compressible, with irregular rhythm. On drawing the finger nail lightly over the surface

a red line results, "the cerebral stain" of Rousseau. The symptoms grow progressively worse with exaltation of the special and general senses; the least pinch or even touch causing exquisite pain; *spasmodic movements of the muscles*, with *contraction and rigidity*, at times *opisthotonus*. Duration of this stage is about two weeks.

*Stage of depression;* the result of the pressure of the exudation; the pulse slow and compressible with irregular rhythm; temperature depressed; tendency to *somnolence* alternating with quiet *delirium*, mental stupor, continual movement of the fingers, as in picking up objects; convulsions from time to time, strabismus, oscillation of the eyeballs, followed by intervals of wakefulness, when the headache is excruciating, causing the peculiar, unearthly shrill cry or shriek, "the hydrocephalic cry," associated with contraction of the muscles of the face, as if suffering were experienced; finally *collapse*, occurring with the "Cheyne-Stokes" respiration, the *coma* deepening, followed by death, *convulsions* often ending the scene. Duration, from a day or two to two weeks.

**Diagnosis.** Acute meningitis and tubercular meningitis have closely analogous symptoms during the stage of excitation, but the history and clinical course of the two maladies determine the diagnosis.

**Prognosis.** Unfavorable. Usual duration, three or four weeks after fully developed prodromes. If ushered in by convulsions the duration is shorter.

**Treatment.** Most unsatisfactory. No means of retarding the disease. Treat symptoms as they develop. Blisters, leeches, active purgation, pustulating ointments, *potassii iodidum* and *hydrargyrum*, are all useless.

If the hereditary tendency be marked, nutritious food, *oleum morrhuae*, *ferri iodidum* and *quinina* may somewhat delay the development of the affection.

### ACUTE HYDROCEPHALUS.

**Synonyms.** Acquired hydrocephalus; serous apoplexy.

**Definition.** Strictly speaking, *hydrocephalus* signifies water in the brain; but it is here restricted to the presence of a serous fluid in the arachnoid spaces, in the pia mater, in the ventricles, and in the brain substance (*cœdema*); characterized by the more or less sudden development of cerebral excitation, followed by depression and usually death.

**Causes.** Most common between the ages of one and five, although it may occur at any age. "The predominance of the nervous system in the bodily conformation" is a strong predisposing cause. Among the exciting causes are unfavorable hygienic conditions, dentition, eruptive fevers, blows on the head, mechanical causes preventing the return of the blood from the vena Galeni and the right sinus, compression of the jugular vein, diseases of the right heart, and Bright's disease.

**Pathological Anatomy.** The effusion may be limited to the ventricles, although there is usually considerable distention of the subarachnoid spaces and œdema of the pia mater and neighboring portions of the brain, whence results more or less softening, especially around the ventricles. The choroid plexus is hyperæmic and may be the seat of minute extravasations.

**Symptoms.** There are three varieties of acute hydrocephalus with characteristic symptoms, to wit: *comatose*, *convulsive* and the *ordinary*.

*Comatose variety*, known also as "serous apoplexy," begins abruptly with the phenomena of apoplexy, the result of the sudden effusion. The pressure is usually so great on the medulla oblongata that it ceases to functionate, death resulting in a few hours, rarely lasting several days.

*Convulsive variety*, the result of Bright's disease or a general dropsy, is ushered in with headache, nausea and vomiting, followed in a day or two with *convulsions*, passing into coma, which usually terminates fatally, although rarely a remission may precede death for a day or two.

*Ordinary variety*, the most common in children, begins with feverishness, headache, vertigo, photophobia, restlessness, nocturnal delirium, insomnia, twitching and spasmoid contractions of the muscles and great hyperæsthesia of the skin. Such symptoms continue for several days, when convulsions occur, followed by death, or a continuance of the symptoms, followed by rigidity, stupor and death.

**Prognosis.** Unfavorable.

**Treatment.** An attempt may be made to remove the fluid by diuretics and full doses of *potassii iodidum*.

## CONGENITAL HYDROCEPHALUS.

**Synonym.** Chronic hydrocephalus (?).

**Definition.** An excessive accumulation of the cerebro-spinal fluid—a cerebral dropsy—in the ventricles—*internal hydrocephalus*, or in the meshes of the pia mater—*external hydrocephalus*, or in both—*mixed hydrocephalus*; characterized by enlargement of the head and more or less pronounced nervous phenomena.

A disease of infants or very young children.

**Causes.** Imperfect or arrested development of the brain or its membranes. Occurs in the offspring of tubercular, scrofulous or syphilitic parents. Inflammatory changes in the ventricles and ependyma.

**Pathological Anatomy.** Enlargement of the head is the chief external pathological condition, although there is no constant ratio between the size of the head and the amount of fluid, the quantity varying from an ounce to a pint or more. The liquid is transparent, of a straw color, containing a small amount of albumin and chloride of sodium.

If the quantity of fluid be small the ventricles are simply distended, if the amount be large the optic thalami and corpus striatum are depressed and flattened, the roof of the ventricles thinned and the foramen of Monro is greatly enlarged. The enlargement of the head may occur before birth and impede or prevent natural delivery, or the head may be normal at birth and increase after. As enlargement progresses the bones are so thinned as to be translucent, the fontanelles and sutures are widened, the lateral portions of the cranium project, the forehead bulges out over the eyes, and the orbital plates are depressed, forcing the eyes outward and downward, producing a variety of exophthalmus; the head has an irregular, triangular shape, the base of the triangle being the top of the head. The scalp being stretched by the pressure within, becomes tense and thin and but scantily covered with hair, the veins which ramify in it are unusually prominent and large, and the entire head is elastic on pressure, from the amount of liquid beneath.

Hilton, in *Rest and Pain*, says, "In almost every case of internal hydrocephalus which I have examined after death I found that this cerebro-spinal opening (between the fourth ventricle and the spinal canal) was so completely closed that no cerebro-spinal fluid could

escape from the interior of the brain; and, as the fluid was being constantly secreted, it necessarily accumulated there, and the occlusion formed, to my mind, the essential pathological element of internal hydrocephalus."

**Symptoms.** The increased size of the head, with the emaciated condition of the child, who seemingly eats well, is what first attracts the attention. The head appears too heavy, the eyes have a prominent but downward direction, the face is devoid of expression, old and wrinkled, the voice feeble; the mental development is not in comparison with the age. When the period for standing or walking arrives the power is found wanting. The further history is but a continuation and exaggeration of this, until *convulsions* occur, which sooner or later terminate fatally.

The duration of congenital hydrocephalus is usually slow but progressively worse. The majority terminate within the first year; cases are recorded of ten and fifteen years' duration.

**Diagnosis.** In rachitis the volume of the head is increased, due, in part, at least, to a deposit of calcareous matter on the exterior of the cranial bones. Rachitis may be mistaken for hydrocephalus in cases in which the amount of liquid is small. The differential diagnosis is based on the shape of the head, round in rachitis, square or triangular or with prominences in hydrocephalus; with the persistent downward direction of the eyes and the elasticity of the head on pressure.

**Prognosis.** Unfavorable. Arrest of progress and even cures are reported. Spontaneous cures are reported following the accidental discharge of the fluid. But such reports are exceptional.

**Treatment.** The use of the finest aspirator needle to evacuate the fluid is fully justifiable. The proper situation for the puncture is the coronal suture, about an inch or an inch and a half from the anterior fontanelle. Firm but gentle compression of the cranium with adhesive strips should be made during the escape of the fluid and afterward. A few ounces of fluid only should be withdrawn at a time. The internal use of *potassii iodidum* is recommended.

All measures that tend to promote the constructive metamorphosis are to be used.

## CEREBRAL ABSCESS.

**Synonym.** Acute encephalitis ; suppurative encephalitis.

**Definition.** An acute suppurative inflammation of the brain structure, either localized or diffused, primary or secondary ; characterized by impairment of intellect, sensation and motion.

**Causes.** *Primary cerebral abscess* is exceedingly rare. Pyæmia ; glanders ; embolus from ulcerative endocarditis.

*Secondary cerebral abscesses* result from injuries to the cerebral tissues, to wit : apoplexy, embolism, thrombosis, and injuries to the cranial bones.

**Pathological Anatomy.** Abscess of the brain affects the left side more frequently than the right. They are usually encysted or inclosed in a limiting membrane. Abscess of the brain may be single or multiple, varying in size from an almond to an egg.

It occupies a limited and well-defined region of the cerebral tissue, to wit : either corpora striata, optic thalami, gray matter of the cortex, the cerebellum, or the white matter of the hemispheres.

"The initial stage at the site of the abscess is hyperæmia. Minute extravasations take place (capillary hemorrhages), giving to the inflamed area a dark, reddish color, whence the term red softening. Migration of white corpuscles, diapedesis of some red corpuscles and exudation of serum holding albumin and fibre in solution, occur simultaneously. The brain tissue, being soft and easily broken up, is rapidly disassociated and its elements disintegrated, and in a short time a soft, pultaceous, red mass results, which more and more assumes a purulent character, becoming first reddish-yellow, then yellow or greenish-yellow, ultimately almost white. The injury caused by an abscess is not limited to the portion of the brain inflamed, but the neighboring territory is in the condition of collateral hyperæmia and œdema" (Bartholow).

**Symptoms.** A concise description of the symptoms of abscess of the brain is very difficult, on account of the wide variations dependent on its location, and also the difficulty of isolating it from the affections to which it is secondary.

The onset varies according to the cause, although all cases are associated with headache, irritative fever, persistent and spreading paralysis, and convulsions.

If following apoplexy, thrombosis, or emboli, there occurs fever and

delirium, the paralysis remaining and spreading with spasmodic contractions of the affected muscles.

Occasionally cases run a chronic course, the onset rather insidious; dull, persistent headache, changed disposition, peevish, irritable, unreliable, with decline of moral sensibility; easily fatigued by mental work; inability to stand exertion; memory impaired; vertigo; dyspepsia, soon followed by slight palsies, which progressively increase, becoming general, with involuntary discharges, death following from exhaustion.

**Diagnosis.** A positive diagnosis is only possible by a close study of the clinical history, as the symptoms at times indicate meningitis, cerebral congestion, epilepsy or cerebral tumor.

**Prognosis.** The usual termination is in death. The course depends upon the character and extent of the injury, varying from a few days to several months.

**Treatment.** Surgical treatment has been attended with marked success in some cases of abscess of the brain, the withdrawal of the pus being followed by recovery. For traumatic abscess the operation of trephining is indicated. Symptomatic treatment for relief of the various symptoms as they arise.

## INTRA-CRANIAL TUMORS.

**Synonym.** Cerebral tumors.

**Definition.** Tumor of the brain is either a growth in the cerebral tissue, on the meninges, or in the vessels; characterized by symptoms of pressure upon the brain structure.

**Causes.** Injuries to the head; syphilis; changes in the vessels; tubercle and cancer; hereditary.

**Pathological Anatomy.** The size of tumors vary, and may become as large as an orange before they will give rise to symptoms.

Tumors of the brain are of various kinds, to wit: *vascular tumors*—aneurisms; *parasitic tumors*—cysticercus; *diathetic tumors*—tubercle or syphilis; *accidental tumors*—fibroplastic.

Whatever the character of growth, it produces irritation of the surrounding parts, and by pressure, destruction of the tissues, or it interferes with the arterial or venous flow.

**Symptoms.** Those common to tumors in general are, *headache*, persistent and increasing in intensity, *defects of vision*, even blind-

ness, *defects of hearing, taste and of speech*, the result of paresis of the vocal cords, *vertigo*, associated with nausea and *vomiting*; *convulsions*, epileptiform in character, usually limited to one side of the body, occurring at regular intervals, or confined to the eyeballs or one limb, with *no loss of consciousness*; *palsies*, beginning first as strabismus, ptosis and dilatation of the pupil, of the facial muscles, paraplegia and general hemiplegia; defects of sensibility, to wit: sensations of numbness, and coldness in the limbs and body. Occasionally disturbances of equilibrium manifested by a tendency to go backward or turn to the right or left; intellectual faculties well preserved until late in the affection, when the memory becomes impaired or lost for certain articles, and finally a gradually advancing imbecility.

**Diagnosis.** Rarely can a positive diagnosis be made. The following points will aid: long-continued, persistent headache, without appreciable cause, epileptiform convulsions, unilateral, without loss of consciousness, difficulty of vision, hearing and speech, associated with nausea and vomiting, and local and general palsies.

The location of the tumor may be determined by the more or less pronounced character of certain symptoms.

The diagnosis of the character of the growth can only be determined by a close study of the history.

**Prognosis.** Unless of syphilitic origin, unfavorable; but it is to be borne in mind that all syphilitic tumors of the brain do not have a favorable termination.

**Treatment.** Unsatisfactory. Mostly symptomatic. As benefit occasionally follows the use of *potassii iodidum*, gr. xx, three times a day, or *ext. ergotæ fld.*, 3ss-j three times a day, continued until their physiological effects are produced, these remedies should be used in all cases, discontinuing them if no benefit follow.

The surgical treatment of tumors of the brain was given a great impetus from the report of the case operated upon in the practice of Hughes-Bennett. The surgical treatment is promising for the future.

## APHASIA.

**Definition.** The inability to use spoken language or give vocal utterance to ideas.

*Amnesic aphasia*, or loss of the memory of words by which ideas are expressed.

*Ataxic aphasia*, the inability to combine the different parts of the vocal apparatus for vocal expression, although the memory of words still remains, so that the afflicted person can write his ideas intelligently.

*Agraphia*, the inability to recognize and make the signs by which ideas are communicated in written language.

*Amnesic agraphia*, the inability to combine the muscular apparatus —“writers’ cramp.”

*Paraphasia*, the mental state in which the wrong words are used to express the idea.

*Paragraphia*, the state in which wrong or meaningless written signs are used to express the idea.

**Pathological Anatomy.** The distinction between aphasia and aphony must be clearly determined.

Aphasia is not the result of any one specific lesion, but occurs during the course of several, to wit: occlusion of certain cerebral vessels; cerebral hemorrhage; cerebral abscess or softening; meningitis; tumors; mental or moral causes; hysteria.

It is now almost definitely determined that lesions of the left middle cerebral artery, island of Reil, third frontal convolution, and parts of the corpus striatum, are associated in the production of aphasia. The lesions are usually upon the left side of the brain, the aphasia being associated with right hemiplegia.

**Symptoms.** The degree to which articulate language is impaired varies, from the loss of a few words to complete inability to communicate ideas. The intellect does not suffer in proportion to the loss of words; for, showing the individual an article, while he may miscall it, if you call it by name he will recognize it. This inability to convey thoughts is a source of great mental suffering, in some leading to a suicidal tendency.

A strange clinical fact is the strong tendency to profanity shown by aphasic patients.

**Diagnosis.** *Aphonia*, or loss of voice, should not be confounded with aphasia, or the inability to remember words.

*Paralysis of the tongue*, or inability to move this organ, thereby interfering with articulate language, should not be confounded with aphasia, which, as a rule, is not associated with paralysis of the tongue.

**Prognosis.** Controlled entirely by the cause. If the result of

congestion of the brain or a syphilitic tumor, the prognosis is favorable. If associated with hemiplegia the clot may undergo absorption, and recovery follow. If associated with softening of the brain, however, the disease grows progressively worse.

**Treatment.** Depends upon the cause, which must be energetically treated, as the aphasia pursues a course parallel to the associated malady. Cases not associated with cerebral softening have regained the memory of words by a course of carefully conducted speech lessons.

Cases of aphasia of sudden occurrence are strongly diagnostic of injury due to a spicula of bone if a history of a head wound, or from the pressure of a clot, and the operation of trephining will be of benefit.

## VERTIGO.

**Synonym.** Dizziness.

**Definition.** Vertigo or dizziness is a subjective state, in which the individual affected, or the objects about him, seem to be in rapid motion, either of a rotary, circular, or a to-and-fro kind.

**Causes.** The etiology of an attack of vertigo depends upon the particular variety.

*Ocular* vertigo results from the paresis of one or more of the ocular muscles, eye-strain or astigmatism.

*Aural or Auditory* vertigo, or *Ménière's* disease, results from disease of the semicircular canals and cochlea. *Ménière's* disease properly so-called, is a sudden severe vertigo, the result of either a hemorrhage or a serous or purulent exudation into the semicircular canals.

*Gastric* vertigo is the most common variety, and results from either stomachic or intestinal dyspepsia, disordered hepatic function or constipation. "The mechanism of the vertigo is complex. There are two factors; one consists in the toxic effect of the imperfectly oxidized materials which accumulate in the blood; the other is reflex. An impression made on the end organs of the pneumogastric in the stomach is reflected over the sympathetic ganglia." (Bartholow.)

*Nervous* vertigo is associated with migraine, sick or nervous headache, and is also caused by physical or nervous excesses, also to the immoderate use of tea, coffee, alcohol and tobacco. It is also a result of many of the organic diseases of the brain.

*Senile* vertigo is the result of the disordered cerebral circulation resulting from changes in the heart and vessels.

**Symptoms.** In all varieties of vertigo the symptom of a sensation of objects moving around the patient or the patient moving around objects which remain stationary is present in some degree. The attack of giddiness comes on suddenly, with an indistinctness of vision and slight confusion of the thoughts. The patient may fall unless he grasps something to steady himself. *Nausea* and *vomiting* and *cardiac palpitation* with *tinnitus aurium* are often associated with the vertiginous sensations. *There is no loss of consciousness.*

In the ocular vertigo the attack is usually the result of reading, writing, sewing, or other close application of the eyes, the ordinary symptoms of vertigo being preceded by headache, nausea, specks before the eyes, and pain in the eye-balls.

In *Ménière's disease* the vertigo is associated with serious *tinnitus aurium* and the vertiginous sensations being of various forms, such as a see-saw movement, a gyratory motion, right or left; a vertical whirl, or a sensation of rising and falling like unto the swell of the ocean. The symptoms are of long duration, becoming marked in paroxysms. The attack of aggravated vertigo is so sudden and overwhelming at times that the person is suddenly thrown to the ground as if struck with a blow, associated with nausea and vomiting. As the condition continues the character of the individual changes, becoming morose, irritable and suspicious.

Not all cases of *Ménière's disease* become permanent, but it may occur in isolated attacks, the interval being free from all sensations.

Gastric vertigo is by far the most frequent variety. Persons subject to vertigo of this kind live in constant dread of cerebral disease, which frequently results in true melancholia.

The vertiginous sensations usually occur during the course of well-marked and long-standing stomach and intestinal disorders, such as pain or oppression after meals, nausea, pyrosis, heartburn, frequent eructations and constipated or rarely diarrhoea. The abdomen is often distended with flatus. Great pain in the nucha is a very frequent occurrence. The attack may be associated with either hyperæmia or anaemia of the brain. The symptoms are not constant, but recur at intervals, sometimes remote, at others very close on each other.

In nervous vertigo the vertiginous symptoms are usually associated with more or less irritability of temper, restlessness and insomnia. The onset is sudden, after some one of the etiological factors. In megrim there is headache, nausea and vomiting. This form of vertigo

often precedes or replaces the epileptic convulsion, it also often precedes softening of the brain.

In senile vertigo the vertiginous symptoms are the result of anaemia of the brain. The attacks are developed by any exertion, often by merely assuming the erect posture. There is a swimming sensation in the head, darkness falls on the eyes with a sensation of chilliness and prostration.

**Diagnosis.** The diagnosis of the various forms of vertigo can only be determined after a close study of the history and course of the attack. The existence of organic cerebral disease must always be kept in mind in solving any case.

**Prognosis.** This will be influenced by the variety of the vertigo. The prognosis is favorable in ocular and gastric vertigo. Unless the result of organic disease the prognosis is good in nervous vertigo. In auricular vertigo the prognosis is fair, but in genuine Ménière's disease the prognosis is unfavorable, as it also is in senile vertigo.

**Treatment.** For ocular vertigo rest for the eyes and properly adjusted glasses.

For cases of Ménière's disease rest in the recumbent position and the use of full doses of *quinina* (grs. x to xv) daily for a long period, as suggested by Charcot.

For gastric vertigo a careful regulation of the diet. At the beginning of the treatment it is often of great advantage to place the patient on an exclusively milk diet, gradually widening the variety as improvement occurs. In these cases a course of *arsenicum* is often serviceable. If the digestion is torpid, the use of *tinctura nucis vomicis* is indicated. If the bowels are constipated, benefit is obtained from *extractum cascarae sagradae fluidum*.

For nervous vertigo the removal of the exciting cause and the use of such remedies as *ferrum*, *quinina* and *strychnina*, either alone or variously combined.

For senile vertigo, a highly nutritious but easily digested diet, the use of a good *spiritus frumenti* and a course of *hydrargyri chloridum corrosivum* or *arsenicum* with *tinctura ferri chloridum*.

## MIGRAINE.

**Synonyms.** Megrim; hemicrania; sick-headache.

**Definition.** A unilateral paroxysmal pain in the head, periodical, accompanied with nausea, often vomiting, intolerance of light and

sound and incapability of mental exertion, the brain for the time being temporarily prostrated and disturbed.

**Causes.** In the majority of patients the nervous predisposition to migraine is inherited, but whether inherited or acquired, it commonly develops before the age of thirty.

Among the many exciting causes are disturbances of digestion, irritation of the ovaries or womb, worry, exacting mental labor, sexual excesses and insufficient sleep. The causes of many attacks, however, are wrapped in mystery.

**Symptoms.** Attacks of migraine occur in irregular paroxysms, the intervals between being free from pain or nervous disturbance.

For a day or two preceding the paroxysm, it will be ascertained, on close questioning, that there was a feeling of fatigue without apparent cause, heaviness over the eyes, with some flatulency and indigestion.

The attack proper is ushered in by *chilliness, nausea, often vomiting, yawning and general muscular soreness, with intolerance of light, and noises in the ears and incapability for mental exertion and pain of a sharp, shooting character of great intensity and persistency localized most frequently in either the frontal, temporal or occipital regions of the left side, at the same time there is tenderness over the whole side of the head. Rarely the pain is felt on the right side and still more rarely on both sides at the same time. The nausea and other digestive symptoms may follow the onset of the pain instead of preceding it.*

There is more or less disturbance of the circulation, temperature and secretions of the affected parts. At times there is marked contraction of the vessels, when the face is pale, the eyes shrunken and the pupils dilated; again, the vessels may be dilated, when the face is flushed, the conjunctivæ injected and the pupils contracted.

Motion, sound and light aggravate the acute suffering.

The attack may continue with more or less intensity for a few hours to two or three days, the average duration being twenty-four hours.

**Diagnosis.** The symptoms are so characteristic that an error seems impossible. It may, however, be confounded with anæmic headache, hyperæmic headache, dyspeptic or bilious headache and neuralgic or rheumatic headache.

**Prognosis.** While few cases of true migraine are permanently cured, the affection is free from danger to life. In a fair number of

cases the susceptibility to attacks declines as the person advances in years, it being rarely seen after fifty years.

**Treatment.** To abort an attack of migraine or dispel a paroxysm after its onset, two remedies are almost infallible—one is a hypodermic injection of *morphinæ sulphas* (gr.  $\frac{1}{4}$ ) with *atropinæ sulphas* (gr.  $\frac{1}{120}$ ), or *antipyrine* (gr. xx) repeated in an hour or two; a large experience with the latter convinces me that the sufferings of those subject to this distressing malady is a thing of the past. A combination for attacks associated with contraction of the vessels is—

R.	Potassii bromid., . . . . .	gr. xxx	
	Morphinæ sulph., . . . . .	gr. $\frac{1}{4}$	
	vel		
	Codeinæ sulph., . . . . .	gr. j	
	vel		
	Tr. opii deodorat., . . . . .	$\text{M}_\text{L}$ xxx	
	Aquæ menth. p., . . . . .	ad f $\frac{2}{3}$ ss.	M.
SIG.—	Repeated p. r. n.		

In the intervals between the paroxysms measures to improve the general system should be used, and to overcome as far as possible any of the etiological factors in its production.

"If the disposition to the malady is inherited, the prophylaxis is very important, and should include diet, exercise, clothing, and the avoidance of all those conditions which tend to develop an abnormal excitability of the nervous system. The best results have been obtained from galvanization of the superior ganglia of the sympathetic; the positive pole over the ganglion and the negative on the epigastrium in the tetanic (contraction of vessels) form; and the poles reversed in the paralytic (dilatation of vessels) form." (Bartholow.)

## ALCOHOLISM.

**Varieties.** Acute alcoholism ; chronic alcoholism.

**Synonyms.** *Acute variety*, temulentia ; mania-a-potu.

*Chronic variety*, delirium tremens ; dipsomania or oinomania.

It would hardly be correct to consider these terms interchangeable ; they are rather names applied to various conditions due to acute or chronic alcoholic poisoning.

**Definition.** Alcoholism is the term used to designate the physical and mental phenomena induced by the abuse of alcohol.

*Temulentia*, meaning drunkenness ; *mania-a-potu* is an acute men-

tal derangement, occurring in those of strong neurotic tendencies; *delirium tremens* is an attack of delirium associated with tremors in persons with the numerous changes resulting from chronic alcoholism; *dipsomania* or *oinomania*, an alcoholic insanity in which an individual at longer or shorter intervals has paroxysms of alcoholic desires, between which he neither wishes nor craves alcohol.

**Causes.** Predisposing causes are influences arising from unfavorable moral, social and personal conditions. Heredity.

Exciting causes are the immoderate use of alcoholic beverages, of which there are three groups: 1, spirits, or distilled liquors; 2, wines, or fermented liquors, and 3, malt liquors.

**Pathological Anatomy.** *Acute alcoholism.* The brain is the seat of an active hyperæmia; the mucous membrane of the stomach and duodenum is markedly injected and covered with aropy mucus slightly tinged with blood, and the gastric juice is altered in quality and quantity. The kidneys are also the seat of an active hyperæmia.

*Chronic alcoholism.* In this condition of the economy there are no organs or tissues which do not present morbid changes. The gastro-intestinal mucous membrane presents the changes of chronic catarrhal inflammation; the liver, the first organ to receive the poison after the stomach, presents the changes of congestion, cirrhosis or fatty degeneration; the kidneys show chronic congestion and often the changes incident to chronic interstitial nephritis; the muscular structure of the heart may undergo fatty degeneration and the vessels the senile changes of the aged. The brain structure presents the changes of sclerosis in various stages, and there may be chronic meningitis and pachymeningitis with haematooma. The nerves are altered, atrophied and hardened, and the neuroglia, vessels and ganglion cells of the spinal cord show similar changes.

**Symptoms.** *Acute alcoholism*, resulting from the use of a large quantity of alcoholic fluid, occurs with symptoms of mild intoxication, to drunkenness passing to acute delirium and acute coma. The condition begins with a period of exhilaration, passing to semi-delirium and ending in an acute coma, when the breathing is ster torous, the face bloated and congested, the lips swollen and purplish, the pupils contracted, the pulse feeble and slow, the skin cold and clammy, the temperature depressed and frequently control of sphincters lost. An individual so affected is said to be "dead drunk."

The cases of ordinary drunkenness do not often pass beyond the stage of exhilaration ending in a mild coma or sleep.

*Mania-a-potu*, or acute alcoholic delirium, is the direct result of alcoholic excess in those engaged in a sudden debauch, or who have drunk alcoholic beverages very "hard" for a comparatively short period. The individuals grow more and more excitable, lose all desire for food, are unable to sleep, become the prey of horrible hallucinations—"the horrors"—finally terminating in mania which resembles delirium tremens in all save the tremor, which is absent.

*Chronic Alcoholism.* The condition to which this term has been given is truly a disease. It is the result of the continued use of alcoholic beverages until one or more of the morbid organic changes have occurred. These persons are markedly dyspeptic, with coated tongue, fetid breath and early morning vomiting, straining or retching, attended with much distress. There is a gradually developing muscular tremor, progressing to the ataxic gait, and insomnia. The face may either become pallid, flabby and bloated with an imbecile expression, or swollen, rough and dusky, with great bladders under the eyes, with yellow injected conjunctivæ. There is headache, vertigo, and attacks of hallucinations; the memory grows weaker, the judgment less accurate, the moral sense blunted and the will power weak and erratic. These and many other symptoms add to the distress of the individual, which he attempts to overcome by the use of more and more of the poison.

*Delirium Tremens.* In the majority of instances delirium results from a prolonged debauch, in an old drinker. It begins by an increased tremor, insomnia, irritable, excitable manner, followed by the characteristic hallucinations and illusions, during which snakes and all forms of repulsive reptiles are seen, causing the most intense horror and abject fear. There also occur illusions of smell and hearing. This marked excitement is followed by great depression, the skin is cold and clammy, the pulse feeble, the muscular system weak, the mind in a condition of coma-vigil, and a febrile condition, typhoid in character, develops.

The ordinary duration of an attack of delirium tremens is about two weeks, although death may occur at any time from cardiac failure, cerebral hemorrhage, or alcoholic pneumonia. Convalescence dates from the beginning of refreshing sleep, the patient awakening with a clear mind and desire for food. Should the delirium subside, but the

patient continue to mutter and pick at the bed-clothing, the tongue become dry and cracked and the regurgitation of dark brownish and bilious matter occur, the condition is critical and an early fatal termination may be expected.

*Dipsomania or oinomania* is the inherited mental condition which craves the drinking of intoxicating liquors. This is a true mental disease. It manifests itself in periodical attacks of excessive indulgence in alcoholic drinking, or this symptom of this sad disease may be replaced by other irresistible desires of an impulsive kind, such as lead to the commission and repetition of various crimes, the gratification of other depraved appetites, robbery, or even homicide.

The paroxysms at first occur at long intervals, but gradually the intervals become shorter and shorter until the individual entirely renders himself to alcoholic and other excesses.

**Diagnosis.** Profound drunkenness or alcoholic coma may and often is confounded with apoplectic and uræmic coma. Von Wedekind suggests the following method for diagnosing drunkenness: "By simply pressing on the supraorbital notches with a steadily increasing force you may, with certainty of success, bring an unconscious alcoholic to his senses, and thus differentiate between alcoholic and other comas."

The symptoms of chronic alcoholism often bear a close resemblance to the following maladies: general paralysis, paralysis agitans, locomotor ataxia, cerebral and spinal softening, epilepsy, dementia and nervous dyspepsia.

In individuals whose habits are secret the question of diagnosis is attended with considerable difficulty. Anstie lays much stress upon the importance of the following four points, diagnostic of chronic alcoholism; *insomnia, morning vomiting, muscular tremor and causeless mental restlessness.*

**Prognosis.** In acute alcoholism the prognosis is good if the patient is manageable.

In chronic alcoholism the organic changes the direct result of the alcoholic habit tend to shorten life by the production of fatty heart, Bright's disease, insanity, impotence, epilepsy, melancholia and organic brain diseases. The danger in delirium tremens is heart failure or a deepening coma. Acute lobar pneumonia is a very fatal complication of all forms of alcoholism.

**Treatment.** The treatment of a case of drunkenness requires no consideration, as the rapid elimination of the alcohol soon occurs if its ingestion be stopped. *Liquor ammonii acetatis* in large, frequently repeated doses, assists the elimination of the poison.

For *mania-a-potu* the immediate and complete withholding of alcoholic beverages is essential for its successful treatment. If the stomach will tolerate food, and usually it will, milk, diluted with liquor calcis, or seltzer water, or hot beef tea strongly seasoned with capsicum, should be frequently administered, together with such cerebral sedatives as *potassii bromidum* and *chloral*. If the attack be associated with symptoms of cardiac depression, brisk frictions, artificial warmth, stimulating enemata and hypodermic injections of *morphinæ sulphas* (gr.  $\frac{1}{4}$ ) with *atropinæ sulphas* (gr.  $\frac{1}{120}$ ) or *digitalis*, are indicated. "If chloral be inadmissible by reason of weakness of the circulation, *paraldehyde* may be substituted, in doses of from half a drachm to one drachm, repeated at intervals of from one to two hours until quietude is produced." (J. C. Wilson.)

For the collapse following a lethal dose of alcohol, the stomach should be immediately emptied by emetics or the stomach tube or pump and the organ washed out with warm water or coffee, the patient placed in the recumbent position and surrounded with artificial warmth, hot frictions to the lower extremities, the use of artificial respiration or the use of faradism to the thorax, inhalations of ammonia, hypodermic injections of digitalis, strophanthus or atropina. "The flagging heart may be stimulated by occasionally tapping the præcordia with a hot spoon—Corrigan's hammer." (J. C. Wilson.)

*Chronic Alcoholism.*—The combine of symptoms termed chronic alcoholism, are the direct result of the continuous action of a single toxic principle, and no success of even a temporary kind can be expected unless the poison be withdrawn. The rapidity with which this can be accomplished is a question for the skill, judgment and experience of the physician to determine; the chief obstacles to its success will be found moral rather than physical. Next to the disuse of alcohol is the question of diet. Much progress will be made as the appetite and digestion improve, and so great attention should be given to it. The general health will also be benefited by fresh air, exercise, mental occupation and cold or tepid sponging and an occasional hot bath at bedtime. For the combination of symptoms of spirit craving, morning vomiting, muscular tremor, mental restless-

ness and insomnia, no drug is comparable with *strychnia sulphas*, either hypodermically twice weekly or, what is preferable, per the stomach to secure its local action on the mucous membrane. If the insomnia be persistent, in spite of the foregoing treatment, the temporary use may be made of such remedies as *chloral*, *morphina*, *paraldehyde*, or *extractum lupulin ethereal* (gr. j-ijj). In many cases it is desirable, for its mental effect, if no other, to administer what the patient terms a substitute for his alcoholic beverages. The following is a good combination for that purpose:—

Rx. Tincturæ nucis vom., . . . . .	$\frac{2}{3}$ ss	
Tincturæ capsici, . . . . .	$\frac{2}{3}$ j	
Ex. lupulin fld., . . . . .	$\frac{2}{3}$ ij	
Inf. gent. co., . . . . .	$\frac{2}{3}$ iss.	M.

SIG.—Dessertspoonful three or four times daily.

For the anaemia, loss of strength, and mental debility, benefit may follow the use of *syrupus hypophosphitis*.

*Delirium Tremens*.—The patient should be isolated, have a skillful, sensible nurse, the quantity of alcohol entirely withdrawn or greatly reduced, supplied with easily digested nutritious diet, and remedies used to combat the excited nervous system. For this latter purpose no one combination is comparable with hypodermic injections of *morphinæ sulphas* (gr.  $\frac{1}{4}$ ), with *atropinæ sulphas* (gr.  $\frac{1}{20}$ ), repeated p. r. n.; *chloral* in the following combination also acts well, if the stomach be not too irritable:—

Rx. Chloral, . . . . .	$\frac{2}{3}$ ss	
Tr. capsici, . . . . .	$\frac{1}{2}$ ss	
Aquaæ menth. p., . . . . .	$\frac{1}{2}$ vss.	M.

SIG.—Tablespoonful every two hours until sleep, alternated with a cup of hot beef tea to which has been added a bolus of *capsicum*, gr. xx.

Care is necessary that a condition of *coma* be not produced by the remedies mentioned.

For depression and cardiac weakness the internal use of any one of the following drugs is serviceable: *Spiritus chloroformi*, *ammonii carbonas*, *tinctura strophanthus*, or *digitalis*.

*Dipsomania*.—The management of these cases is much the same as has already been mentioned for chronic alcoholism, although the *strychnina* treatment should be given the preference.

## HEAT STROKE.

**Synonyms**—Insolation; sun-stroke; thermic fever; coup-de-soliel; heat exhaustion.

**Definition.**—A depression of the vital powers, the result of exposure to excessive heat. The condition manifests itself as acute meningitis (rare), heat exhaustion (common), and as true sun-stroke.

**Causes.**—Exposure to the influence of excessive heat, either to the direct rays of the sun or artificial heat in confined quarters, or diffused atmospheric heat without proper ventilation.

Among the predisposing causes, which act by lessening the power of the system to resist the heat, are great bodily fatigue, overcrowding and intemperance.

**Pathological Anatomy.**—The action of the heat upon the organism is so sudden, and the malady so rapid in its course, that structural changes have not developed. The left ventricle is firmly contracted (Wood). The right heart and vessels are gorged with dark fluid blood. All the tissues and organs of the body are in a state of great venous congestion. The blood is dark, thin, and either but feebly alkaline or decidedly acid, and its power of coagulability is destroyed. The *post-mortem* rigidity is early and marked.

**Symptoms.** Depending upon the variety.

*Acute Meningitis* the result of exposure to heat is similar to that due to other causes.

*Heat exhaustion* develops with a rapid feeling of weakness and prostration, the surface cool, the face pale, the voice weak, the pulse rapid and feeble, the respirations increased, the vision growing dim and indistinct, noises develop in the ears, the individual, overcome, becomes partially or completely unconscious. In some cases the attack of prostration is sudden, the person falling unconscious, with perhaps convulsions or tremors, and shrunken features.

*Sun-stroke.* The symptoms, developing suddenly, with or without prodromata, are, insensibility, with or without delirium, or convulsions, or paralysis, the surface flushed and hot, the conjunctivæ injected, the breathing either rapid and shallow or labored and stertorous, the pulse quick and either bounding or weak, and the temperature in the axilla ranging from  $105^{\circ}$ , to  $108^{\circ}$ , to  $110^{\circ}$ , with suppression of all glandular

action. Death occurring, the result of asphyxia, or from a slow failure of respiration and cardiac action.

**Diagnosis.** It is of great importance, therapeutically, to distinguish at once between attacks of sunstroke and heat-exhaustion. Cases of sun-stroke are to be differentiated from cerebral hemorrhage and alcoholic insensibility, for which purpose the clinical thermometer is indispensable.

**Prognosis.** Attacks of heat-exhaustion, if properly and promptly treated, favorable. The prognosis of sun-stroke or heat-fever is unfavorable in the majority of cases, death resulting in from half an hour to several hours. Unfavorable indications are, increased temperature, cardiac failure, convulsions, absent reflexes, followed by complete muscular resolution.

Favorable indications are, decline in surface heat and axillary or rectal temperature, stronger pulse, increased depth of respirations, restored reflexes, and return of consciousness.

**Treatment.** Cases of *heat-exhaustion* are successfully treated by placing the patient in the recumbent position, with the head low, and the use of stimulants. If able to swallow administer at once *spiritus vini gallici*,  $\frac{3}{ss}$ -j, with *tinctura opii deodorata*,  $m_{xx}$ -xxx, to be repeated p. r. n.; if he be unable to swallow, the remedies may be thrown into the rectum, or *spiritus frumenti* and *tinctura digitalis* can be used hypodermically. As convalescence occurs tonic doses of *quininae sulphas* and *strychninae sulphas* should be prescribed.

For *sunstroke*, the indications for treatment are the very opposite. The patient is in imminent danger from the extraordinary temperature and measures to reduce it must at once be instituted. Of these none give such excellent results as rubbing with *ice*, or the *cold bath* or *cold pack*, and *cold effusions*, *cold enemata*, and the hypodermic use of *quininae sulphas* or *antipyrine*. The tendency to subsequent rise of temperature is met by wrapping the patient in a wet sheet, or the repetition of the hypodermics mentioned if consciousness has not been regained, when they can be given by the mouth. If convulsions and restlessness occur, the hypodermic use of *morphinæ sulphas*, gr.  $\frac{1}{4}$ - $\frac{1}{2}$ , cautiously repeated, is successful. If symptoms of depression occur, the stomachic, rectal or hypodermic administration of stimulants is indicated.

For convalescence, use *quininae sulphas*, *strychninae sulphas* or *ferrum*.

## DISEASES OF THE SPINAL CORD.

### SPINAL HYPERÆMIA.

**Synonyms.** Spinal congestion; plethora spinalis.

**Definition.** An abnormal fullness of the vessels of the meninges and cord; *active* when arterial hyperæmia; *passive* when venous hyperæmia; characterized by pain in the back, with more or less pronounced disorders of sensation and locomotion.

**Causes.** Cold and exposure; arrested menses; arrest of habitual hemorrhoidal discharge; malaria; protracted erect posture; injuries to the back; certain spinal poisons, as strychnina, picrotoxinum, and alcoholic excesses.

**Pathological Anatomy.** *Active.* The post-mortem appearances are congestion of the meninges and cord, the same vessels supplying both, with numerous points of extravasation, due to the rupture of capillary vessels. The spinal fluid is increased in amount.

*Passive.* A general bluish discoloration, owing to the abnormal fullness of the large anastomosing vessels; the spinal fluid somewhat increased.

**Symptoms.** *Active.* Dull pain in the dorsal or lumbar region, shooting into the hips and thighs, persistent and increased by pressure; tenderness on motion; tingling sensations in the limbs and feet, and sometimes in the hands and arms; a feeling of constriction about the abdomen is often present, with rigidity of the abdominal muscles. *Increased reflexes*, with *disorders of motility*, and when the patient is in the recumbent position, *jerking of the limbs*. On attempting to walk it is accomplished with difficulty, from an *incomplete loss of power*.

If the upper part of the cord be affected, *dyspnœa* and *palpitation* occur.

There often occur painful priapism and frequent nocturnal emissions.

The above symptoms may be followed by a more or less pronounced temporary depression, the sensation diminished and the lower limbs benumbed and heavy, the movements weak.

The *electro-contractility* is preserved, and in many cases even increased or exalted.

**Duration.** From a few hours to several days ; if longer, myelitis may result.

**Diagnosis.** *Anæmia* causes more or less spinal irritability and tenderness ; but the history, pallor and general weakness, unassociated with defects of motility or sensibility, will prevent error.

*Spinal meningeal hemorrhage* is more sudden in its onset, its violence and its range of symptoms.

*Myelitis* and *spinal meningitis* have symptoms in common with spinal congestion, which will be pointed out when discussing those affections.

**Prognosis.** Favorable, recovery occurring in three or four days.

If the symptoms show a tendency to linger, myelitis more or less pronounced will ensue.

**Treatment.** Rest, but avoid lying on the back, cups or leeches along the spine, followed either by the iced or the hot douche, or hot sponges, with active purgation, to diminish the blood pressure.

If the result of suddenly arrested perspiration, *pilocarpus*. If following suddenly arrested menses, *aconitum*. If associated with an active circulation, *potassii bromidum* or *fluidum gelsemii extractum*,  $m.v.$ , every four hours, or *extractum ergotæ fluidum*, f $\ddot{3}$ ss-j, repeated p. r. n. ; in all cases active purgation.

For the passive form, treating the cause, *ergota*, *digitalis*, tonics and purgatives.

## SPINAL MENINGITIS.

**Synonym.** Leptomeningitis spinalis.

**Definition.** Inflammation of the arachnoid and pia mater membranes of the spinal cord, either acute, subacute or chronic ; characterized by pain in the back, rigidity of the muscles, disorders of motility and sensibility. It may be acute or chronic.

**Causes.** Exposure to cold and dampness ; injuries to the vertebræ or membranes ; rheumatism ; puerperal fever ; syphilis.

**Pathological Anatomy.** *Acute.* Hyperæmia of the membranes, with swelling of the tissues, the result of serous infiltration followed by purulent and fibrinous exudations. The roots of the spinal nerves are covered with exudation, and are swollen and soft. The cord proper is more or less congested and œdematosus.

*Chronic.* Adhesions of the membranes, with more or less accumulation of fluid, resulting in atrophic degeneration of the cord from pressure.

**Symptoms.** Although an inflammatory affection, yet its onset is usually subacute, the febrile reaction being moderate, with intense boring *pain* in the back, aggravated by motion, *rigidity of the spine* and a sense of *constriction around the body*, "the girdle." *Spasmodic contractions* of the muscle enervated by the nerves originating at the seat of the lesion, with inability to straighten the limbs. If the lower part of the spinal membranes are the seat, there occur *retention of urine* and *constipation*; if upper part, *dysphagia*, *dyspnoea* and *feeble heart*. The muscular contractions are excited or increased by motion, but uninfluenced by pressure. *Reflex movements* are not abolished. The rigidity and spasmodic contraction of the muscles are followed by *paralysis* more or less complete, death following from paralysis of the muscles of respiration.

If the inflammation extend to the medulla, the above symptoms are associated with *disorders of speech*, *vomiting* and *delirium*.

*Electro-contractility* lessened or absent, both as to motility and sensibility, in the affected parts.

*Chronic form* succeeds to the acute or originates spontaneously, and presents the same form and order of symptoms—excitation and depression.

**Diagnosis.** The points of importance are, deep, boring pain in the back, aggravated by motion but not by pressure, with spasmodic contraction of the muscles, followed by paralysis.

*Mycelitis* will be differentiated from spinal meningitis when discussing that affection.

*Tetanus* may be confounded with spinal meningitis. The points of distinction are: in the former occur early trismus with rhythmical spasms excited by irritation of the skin, whereas irritation of the skin does not in spinal meningitis produce muscular contractions, but movements of the limbs does do so; progressively increasing and not associated with fever.

**Prognosis.** Grave. Death is either sudden, from paralysis of the respiration and of the heart, or gradual, the result of exhaustion.

Critical discharges, such as profuse perspiration, urinary flow or epistaxis occur and are followed by rapid recovery. Cases recovering may have more or less pronounced partial or complete paralysis.

**Treatment.** Rest in bed, upon the side or face. *Cups* or *leeches* along the spine, followed by *ice*, the *hot douche*, *hot sponges*, or *mustard*. Active purgation.

To reduce the amount of blood in the vessels of the cord, *aconitum* and *ergota* combined with an *opium* impression. When paralysis (depression) occurs, *quininae sulphas*, gr. iij, combined with *ext. belladonnae alcoholic*, gr.  $\frac{1}{4}$ , three times a day, or *potassii iodidum*, gr. xx-xxx, three times a day, with flying *blisters* along the spine. If the paralysis still persist, a *hydrargyrum* impression often benefits.

For paralysis, the *galvanic current* to the spine and nerve trunks, and the *faradic current* to the affected muscles, with the deep injection of *strychnina* and the use of *massage*.

### PACHYMENTINGITIS SPINALIS.

**Synonyms.** Pachymeningitis spinalis interna; hypertrophic pachymeningitis; pseudo-membranous pachymeningitis.

**Definition.** An inflammation of the spinal dura mater; characterized by violent pains in the head, neck, shoulders and arms, followed by paralysis of the upper extremities.

**Causes.** Exposure to cold and damp; alcoholism; syphilis; gout; injuries.

**Pathological Anatomy.** *Hypertrophic pachymeningitis* is characterized by an exudation upon the inner surface of the dura mater, which gradually solidifies into a layer of compact connective tissue, which presses upon the spinal cord and nerves, producing a myelitis and an atrophic neuritis, resulting in muscular atrophy.

The most frequent seat of this form of the affection is the cervical region, as first demonstrated by Charcot, whence the term *cervical hypertrophic pachymeningitis*.

In the *pseudo-membranous* form a membranous exudation also occurs, in which large numbers of blood vessels develop and rupture, the hemorrhagic extravasation forming a cyst—*hæmatoma*—which causes pressure on the cord and nerves.

**Symptoms.** The onset is slow and gradual, with irregular *chills* and *feverishness*, *violent pains* in the head, neck, shoulders and arms, continuous but subject to exacerbations, and associated with a *painful constriction* of the upper thorax. These symptoms may continue off and on for several months, when the *muscles* of the painful parts begin to *atrophy*, followed by spasmodic contraction and paralysis.

The general health deteriorates with the progress of the muscular symptoms.

*The electro-contractility is lost.*

**Prognosis.** If early recognized and promptly treated, the hypertrophic form may be cured.

**Treatment.** Rest; nutritious diet; *oleum morrhuae* and the *hypophosphites*; large doses of *potassii iodidum*, and repeated but systematic counter-irritation.

### ACUTE MYELITIS.

**Definition.** An inflammation affecting the substance of the spinal cord, which may be limited to the gray or white matter, and involve the whole or isolated portions of the cord. When the *gray* matter alone is inflamed, it is termed *central myelitis*; when the *white* matter and the *meninges*, it is termed *cortical myelitis*; it may be ascending, descending or transverse in its extension. The disease is characterized by more or less sudden and complete loss of motion and sensation.

**Causes.** Following spinal meningitis; exposure to cold and damp; injuries to the vertebræ; prolonged functional activity of the cord; typhus fever; rheumatism; syphilis; puerperal fever, or during the course of the exanthemata; arsenical or mercurial poisoning.

**Pathological Anatomy.** Intense hyperæmia of the substance of the cord, with extravasations, giving the tissues a reddish brown or chocolate tint, and also serous transudations, resulting in softening of the structure of the cord, the color changing to yellow and white, the nerve elements undergoing fatty degeneration, presenting the appearance and consistency of cream. The membranes also undergo more or less change.

**Symptoms.** The severity of the symptoms depends upon the extent and location of the inflammation.

The onset is usually sudden, with a *chill*, *fever*,  $103^{\circ}$ , *frequent pulse*, with *alterations in sensibility and motility*, to wit: *pain* in the back, aggravated by touch and by heat and cold, with sensations of *formication* ("pins and needles"), the limb feeling as if asleep, or else complete *anesthesia*, associated with severe *neuralgic pains*.

The distinction between *anesthesia*, insensibility to touch, and *analgesia*, insensibility to pain, must be clearly determined.

A sensation of *constriction* around the body and limbs, as if encircled by a tight cord, "the girdle pains;" rapidly developing *paraplegia*, complete in a few hours, with involuntary discharges. The *reflex functions* are usually abolished, as seen by attempting to cause move-

ment of the limbs by tickling the feet or by striking the patella tendon ; rarely are they diminished, very rarely exaggerated. The temperature of the affected limbs is lowered three or four degrees.

Sloughs and bedsores and muscular atrophy result if the anterior cornuæ—the trophic centres—are affected.

The above symptoms of *loss of motion and sensibility* are associated with more or less pronounced vomiting, hepatic disorders, irregularity of the heart, dyspnœa, dysphagia, apnœa and painful priapisms. The urine is markedly alkaline in reaction.

Among the late manifestations are *shooting pains* and *spasmodic twitchings* or *contractions* of one or all of the muscles of the paralyzed parts.

*The electro-contractility* is abolished in the paralyzed parts.

**Diagnosis.** *Acute spinal meningitis* is distinguished from acute myelitis by severe pains, increased by pressure, with muscular contractions increased by motion, followed by paralysis much less profound than the paraplegia of myelitis ; in spinal meningitis there exists cutaneous and muscular hyperæsthesia, which is absent in myelitis.

*Congestion of the spinal cord* is characterized by the mild character and short duration of all the symptoms.

*Hemorrhage in the spinal canal* is abrupt, with irritative symptoms, slight paralysis, preserved reflexes and electro-contractility.

The principal diagnostic points of acute myelitis are the "girdle" around the limbs or body, rapid and complete paraplegia, lowered temperature in the affected parts, early and persistent sloughing (bedsores) and alkaline urine.

**Prognosis.**—Varies according to the location of the lesion.

If the paralysis is of the *ascending variety*, death occurs within a few days, from paralysis of the muscles of respiration.

If the *trophic centre* is affected, there occur bedsores, intense pyelonephritis and cystitis and changes in the joints ; death from exhaustion, in several weeks.

*Central myelitis*, or inflammation of the *gray matter*, is rapid in its progress, death occurring in a week or two.

The morbid process may be arrested and the general health restored, but some spinal symptoms will persist.

**Treatment.** Absolute rest is essential to even secure a palliation of the symptoms.

*Locally*, considerable relief follows the use of hot-water bags or sponges dipped in *hot* water and applied along the spine every few hours.

The remedies most strongly recommended are : *digitalis*, *ergota*, *belladonna*, *bromides*, *cimicifuga* and *quinina*, although I have never observed a cure with any plan of medication, after it was fairly established, save those due to *syphilis*, by large doses of *potassii iodidum*.

### INFANTILE SPINAL PARALYSIS.

**Synonyms.** Poliomyelitis anterior acuta ; essential paralysis of children.

**Definition.** A rapidly developed inflammation of the anterior horns of the gray matter of the cord, occurring suddenly in children, at times in adults—*acute spinal paralysis of adults* ;—characterized by mild fever, muscular tremors and twitchings, and paralysis of groups of muscles.

**Causes.** Essentially a disease of early life—the second month to the third or fourth year. The fact of its having occurred in adults must be borne in mind. Cold and damp; dentition (?) ; injuries to the spine ; developed during convalescence from the acute exanthemata.

**Pathological Anatomy.** The early changes are : medullary hyperæmia, vascular exudation and inflammatory softening, although the naked eye may not recognize any changes. Microscopical examination reveals inflammatory softening of the anterior horns of the gray matter. Among other constant lesions are atrophic degeneration of the multipolar ganglion cells and of the anterior nerve roots.

The changes noted as occurring in the cord are usually limited to the dorso-lumbar and cervical enlargements.

As a direct result of the changes in the *trophic centre* and the nerve degeneration of the muscular fibres supplied, there ensue changes in the bones and joints, leading to great deformities.

**Symptoms.** The onset of the affection varies ; it is usually sudden, with an attack of *mild fever* of a remittent type, of a few days' duration, on recovery from which it is noticed that the child is *paralyzed*. Rarely the paralysis may be preceded by *convulsions*.

The *paralysis* may affect both arms and both legs, the legs alone, or only one of the four extremities ; it may, but very rarely, be a

hemiplegia. The bladder and rectum are not affected, nor can anaesthesia or numbness be detected. The temperature of the paralyzed limb is low and the appearance cyanosed. After a few days there is a slight improvement in the paralyzed parts, although the muscles show a rapid wasting, which is progressive until all muscular tissue is gone.

The *reflex movements* are *impaired* or *abolished*.

The *electro-contractility* by the faradic current is *abolished* in the paralyzed parts.

With the *galvanic* or constant current the "reactions of degeneration" are developed. To fully understand the meaning of this term a knowledge of the normal electrical reactions is necessary.

The normal formulæ for the production of muscular contraction in the physiological state are as follows, the strength of the current being barely capable of causing fair contractions:—

*First.* The most effective contractions are produced by the *cathode (negative) pole* on closing the circuit.

*Second.* The second most effective are produced by the *anode (positive) pole* on closing the circuit.

*Third.* The next most effective is by the *anode pole* on opening the circuit.

*Fourth.* *Cathode pole* contractions on opening circuit are rarely seen in the physiological state.

The "reactions of degeneration" are shown by any reversal of the regular formulæ, to wit: if the *anodal* closure shows stronger contractions than *cathodal* closure; still greater degeneration is shown if *anodal opening* contractions are stronger than either of the above; and almost complete degeneration is shown by the complete reversal of the normal formulæ as shown by distinct *cathodal* opening contractions.

**Diagnosis.** Hemiplegia from acute cerebral affections in children can be distinguished from infantile paralysis by the disorders of intelligence and the special senses, and the perseverance of the normal electro-contractility.

Paralysis of myelitis occurs in older persons, and is associated with disturbances of the genito-urinary organs and bedsores.

Pseudo-muscular hypertrophy, with paralysis, begins gradually, becoming progressively worse with increase in the size of the limbs.

**Prognosis.** Depends upon the treatment. If prompt and proper,

recovery may be said to be the rule. Mild cases recover within a few days, others as many weeks, more severe cases a month or two. If proper treatment be not pursued for several months or years, the question of final recovery can be determined by testing for the "reactions of degeneration" with the galvanic current. There is no danger to life.

**Treatment.** The diagnosis during the initial fever is impossible, so that its treatment is symptomatic. On the appearance of the *paralysis complete rest*; hot spinal douche, mild *galvanism*, and internally, *quinina, belladonna and ergota*.

With the improvement that follows the above measures, use internally, *tinctura nucis vomicae*,  $\text{mij-iij}$  t. d., or hypodermic injections of *strychninæ sulphas*, gr.  $\frac{1}{60}$  to  $\frac{1}{100}$  twice a week, and *faradism* to the paralyzed muscles.

## CHRONIC PROGRESSIVE BULBAR PARALYSIS.

**Synonyms.** Glosso-labio-laryngeal paralysis; bulbar paralysis.

**Definition.** A progressive muscular paralysis of the laryngeal muscles, tongue, soft palate and lips.

**Causes.** Obscure. Rare before the fortieth year. Among many others are named cold, rheumatism, gout, syphilis and injuries about the neck.

**Pathological Anatomy.** "Degenerative atrophy of the gray nuclei in the floor of the fourth ventricle; with atrophy and gray discoloration of the nerve roots from the medulla, especially of the facial and hypoglossal nerves." "Atrophy and disappearance of the motor ganglion cells is always to be noted. It may be the sole lesion."

"The nerves going to the muscles exhibit sclerosis of the neurilemma, and the degenerative atrophy is found in the nerve roots coming from the bulb."

**Symptoms.** The disease begins insidiously. There is first noticed some *difficulty in articulation*, from want of precision in movements of the tongue, which increases until that organ is completely paralyzed. The *paralysis* gradually invades the *soft palate* and *pharyngeal* muscles, causing difficulty in deglutition, the *orbicularis oris*, preventing closure of the lips, the *laryngeal* muscles interfering with *articulation*. When the disease is fully developed the condition of the patient is most pitiable, indeed; articulation is impaired

or impossible, deglutition interfered with, the lips remaining apart allowing the saliva to dribble from the mouth, and liquids to return through the nose if attempts are made to swallow them. As the malady advances soon the pneumogastric nucleus becomes involved, causing loss of voice, difficulty of respiration and cardiac irregularity. The general health gradually suffers from insufficient nutrition and imperfect respiration, although the mind is clear until the end. The "reactions of degeneration" are present.

**Diagnosis.** It can hardly be confounded with any other malady.

**Prognosis.** Unfavorable. The duration is from one to five years.

**Treatment.** Entirely symptomatic. "*Galvanism* is the most promising remedy. Stable applications, the electrodes on the mastoid processes, and in the opposite direction, galvanization of the sympathetic, and applications to the lips, tongue and fauces, should be persistently used." (Bartholow.)

## SPINAL SCLEROSIS.

**Synonym.** Duchenne's disease.

**Definition.** A myelitis; an increase in the connective tissue of the spinal cord, with atrophy of the nerve structure proper.

**Varieties.** I. *Lateral sclerosis*; II. *Cerebro-spinal sclerosis*; III. *Posterior sclerosis or locomotor ataxia*.

**Causes.** Generally a hereditary neuropathic diathesis; syphilis; mineral poisons; shocks or injuries to the cord; exposure to cold and wet; mostly occurring between the ages of thirty-five and fifty-five; males more liable than females. It is said that railroad enginemen and firemen as well as conductors and other trainmen, suffer from this and other spinal diseases by reason of the concussion.

**Pathological Anatomy.** The changes in the cord are gradual in their development and follow a longitudinal instead of a transverse direction.

The form, consistency and color of the cord are altered, it being atrophied, indurated and of a grayish color.

The changes are hyperplasia of the connective tissue, with granular degeneration, atrophy and disappearance of the proper nerve elements. The nerve roots undergo the same fibroid change. The joints undergo remarkable atrophic degeneration.

## LATERAL SCLEROSIS.

**Synonyms.** Antero-lateral sclerosis; spasmodic tabes dorsalis, (Charcot); spastic spinal paralysis (Erb).

**Pathogeny.** The site of the lesion is the lateral white columns, in some cases extending to the anterior horn, extending the whole length of the cord. The changes consist in an interstitial hyperplasia, of the connective tissue and an atrophy of the nerve elements.

**Symptoms.** The chief symptom is *paraplegia*, or entire loss of motion in the lower extremities. Preceding the paralysis there occur *jerking and twitching*, with *cramps and stiffness* of the muscles of the affected parts. As the disease is progressing the gait is of a peculiar character, termed by Hammond "the waddle," the patient stepping on the toes and showing a tendency to fall forward. There is a gradual and increasing feeling of heaviness and weakness in the affected limbs. Sensation is unaffected. Reflex phenomena are preserved, at times greatly exalted. As the morbid process extends upward, the superior extremities suffer in the same manner as those of the lower.

*Electro-contractility* early impaired, and gradually declining until abolished.

## CEREBRO-SPINAL SCLEROSIS.

**Synonyms.** Multiple sclerosis of the brain and cord; cerebral sclerosis; spinal sclerosis; disseminated sclerosis (Charcot).

**Pathogeny.** The disease consists of the development of patches of grayish, translucent, tough nodules, varying in size from a minute microscopical object up to the size of a walnut, varying in number and widely distributed in the white matter of the hemispheres, ventricles, optic thalamus, corpus striatum, peduncles, pons and cerebellum, while in the cord they are found in both the white and gray matter and in the columns. The deposits are also found in the nerve roots and nerve trunks. The nodules are composed of the neuroglia much altered and a newly-formed connective tissue. The result of the nodules is pressure upon the nerve structure, ending in its degeneration.

**Symptoms.** Charcot divides this variety of sclerosis into three varieties, depending upon the site of the marked changes, as the brain, the cord or a combination of the two. The latter variety is the more common.

Rarely the malady is ushered in with apoplectiform symptoms, but generally the onset is insidious, with *pains* more or less severe in the limbs and back, which are attributed by the patient to rheumatism. Also a feeling of formication, itching and burning in the limbs. Loss of coördination of the hands in writing, or the feet in walking, followed after a time by *paresis*, more or less general, with *contracture* of the muscles. Voluntary movements of the paretic limbs develop a *tremor*—the *shaking tremor*—which subsides when the limbs are at rest. It is these motor symptoms that have given rise to the “waddle,” or “hop” gate when walking. There are also present *headache*, *vertigo*, *mental disturbances*, *nausea*, *dyspeptic distresses*, disorders of *vision* and *hearing*, *sexual disturbances*, *vesical disorders*, and often the development of bedsores.

The disease is progressive, the symptoms developing as the various nerve tracts are invaded.

**Duration.** Ranges from a year to twenty years, an average being five or ten years.

#### PROGRESSIVE LOCOMOTOR ATAXIA.

**Synonyms.** Posterior spinal sclerosis; tabes dorsalis.

**Pathogeny.** The sclerosis begins and may be confined to the posterior columns in the upper lumbar and dorsal regions. Frequently it extends the entire length of the cord and invades the lateral columns. The sclerotic changes also invade the sciatic, crural and brachial nerves.

**Symptoms.** Locomotor ataxia may be divided into three periods: 1, disturbances of sensation; 2, loss of coördinating power; 3, paralysis.

The onset of the disease is gradual by *sharp*, *darting*, *electric-like* *pains* in the lower limbs, with disorders of the gastro-intestinal and genito-urinary tracts. Associated with the pains is a *loss of sensation* in the feet, the patient being unable to distinguish between hard and soft substances in walking, and, if the upper portion of the spinal cord be affected, is unable to coördinate the muscles of the fingers sufficiently to button his clothing. A sensation of formication over the surface, especially over the lower limbs, and about the waist, the knee and the ankle.

*Loss of coördination*, the subject being unable to walk upon a straight line with his eyes closed, and with difficulty if his eyes are

opened. Inability to preserve the erect position with the feet close together, and as the malady progresses he throws his feet and legs in the most grotesque manner. Although the patient is unable to coördinate the muscles, their power is not lost, for, on being supported, he can kick or strike with his usual force.

The sight is early impaired; either double vision or inability to distinguish between different colors. As the disease progresses the sensation becomes more and more blunted and pain is slowly felt, in cases it being several minutes until the sticking of a pin is felt. A characteristic sign of the disease is the abolition of the patellar tendon-reflex as well as other reflexes in the lower limbs. Loss of the sensation of temperature also occurs. The electro-contractility is decreased in the affected limb. General emaciation is marked.

*Paralysis* finally ends the suffering of the patient. There is generally an entire absence of cerebral phenomena.

**Diagnosis.** The symptoms of these three varieties of sclerosis are so characteristic that with care an error in the diagnosis seems impossible.

*Chronic myelitis* is characterized by paralysis, and the course of the affections are otherwise so different that an error should not occur.

*Disease of the cerebellum* presents symptoms of disordered coöordination, but they are the result of vertigo, and associated with headache, nausea and vomiting.

*Paraplegia* is a true paralysis, while sclerosis is not. Neuralgic pain is not a symptom of paraplegia.

*Paralysis agitans* may be mistaken for disseminated sclerosis. Chief points in the diagnosis are the presence in paralysis agitans of the fine tremor continually without shaking of the head, while in cerebro-spinal sclerosis the tremor is produced only on movement of the muscle, and is associated with shaking of the head. Paralysis agitans, a disease of middle life, sclerosis under forty years. Changes in the voice, speech and vision are present in cerebro-spinal sclerosis, but absent in paralysis agitans.

**Prognosis.** Unfavorable. Few if any recoveries are recorded of antero-lateral or disseminated sclerosis, although rarely their progress has been retarded for a long time. There are some claims of recoveries of locomotor ataxia in the early stage, but that a cure of a genuine case, extending to the second stage, is ever effected, seems very questionable.

**Treatment.** In the management of the various scleroses, *rest*, as near absolute as possible, is of the first importance,—it will be all the more effective if it be in bed, for a period of several months.

Following the suggestion of Erb, use may be made of *cold along the spine*, in the shape of cold sponging, cold spinal pack or short application of the cold douche to the spine. The *galvanic continuous current* along the spinal column is warmly advocated, with *faradism* to the wasting muscles.

*Potassii iodidum*, or *hydrargyri chloridum corrosivum*, in full doses, or *aurii et sodii chloridum*, gr.  $\frac{1}{25}$ , three times a day, often remarkably retard the progress of the affection. The best results are obtained, however, from *argentii nitras*, gr.  $\frac{1}{4}-\frac{1}{2}$ , or *oxidum*, gr.  $\frac{1}{2}$ , three times a day, withholding it at intervals of a few weeks, to prevent discoloration of the skin (*argyria*).

Temporary success at least, seems to have followed, in some cases of locomotor ataxia, from the “*suspension treatment*” as recommended by Charcot. The treatment consists of the suspension of the patient during a period varying from one to four minutes, by means of the Sayre apparatus for applying the plaster jacket in spinal deformities.

The severe and sharp pains require treatment, at first giving preference to any of the substitutes of opium, but finally *opium* itself will have to be resorted to.

The diet should be of a nutritious, easily-assimilated character. Nutrition can also be promoted by the use of *oleum morrhuae* and *syrupus calcii lacto-phosphatis*.

## PROGRESSIVE MUSCULAR ATROPHY.

**Synonym.** Wasting palsy.

**Definition.** A gradual, progressive wasting and atrophy of the voluntary muscular system, resulting from trophic changes due to a central nerve lesion.

**Causes.** In many instances the disease is hereditary. A predisposing cause seems to exist in those who habitually use one set of muscles. Exposure to cold and damp; lead, syphilis; injuries to the spinal column.

**Pathological Anatomy.** Two theories as to the origin of the pathological changes are held: one that the initial lesion is in the

cord (Charcot), the other in the muscular interstitial connective tissue (Friedreich).

The morbid alterations are of two groups—spinal and muscular.

The spinal changes consist in the atrophy and degeneration of the anterior columns, wasting and disappearance of the multipolar ganglion-cells of the anterior horns, and hyperplasia of the neuroglia, and wasting, atrophy and degeneration of the anterior nerve roots.

The muscular changes consist of a progressive wasting of the muscular tissue, with increase of the interstitial connective tissue. "The final result is, that the muscle is converted into a mere fibrous band with numerous fat-cells, the development of this latter material taking place outside of the muscular elements and in the newly-formed connective tissue." (Bartholow.)

**Symptoms.** The invasion is gradual, the disease having been in progress some weeks or months before the patient discovers its existence.

*Wasting begins* usually in the *hand*, the first dorsal inter-osseus being the first to be attacked, then the muscles of *thenar* and *hypothenar eminence*, then the deltoid, and so on from muscular group to group. Often, however, the extension is very erratic in its course, jumping from one group to another at some distance.

In the immense majority of cases the disease is permanently limited to one or a few groups of muscles in the upper, or more rarely in the lower extremities. The only muscles not yet known to be attacked are those of mastication and those that move the eye-ball (Roberts).

*Fibrillary contractions* is an early symptom, continuing more or less marked so long as any muscular fibres remain. It consists of *wave-like movements* of the muscles, excited automatically, by draughts of air or percussion. Co-incident with the wasting is *loss of power, disorders of sensation, coolness of the surface, and pallor of the surface*.

The natural roundness and contour of the body and limbs are changed, the bones standing out in unaccustomed distinctness, giving the individual the appearance of a skeleton clothed in skin. The hand is frequently the seat of a very singular deformity—the "claw-shaped" hand.

The *electro-contractility* is preserved so long as muscular fibres remain.

**Diagnosis.** When wasting palsy is fully developed its diagnosis

is a simple matter. In its early stages a doubt may exist, but attention to the history, symptoms and progress will determine the question.

**Prognosis.** Very unfavorable, although the danger to life is often very remote. The disease may be arrested and remain stationary for years.

**Treatment.** Internal medication seems to have no effect on the malady, although if mineral poisoning be suspected *potassii iodidum* should be used, and if syphilis be suspected a course of *potassii iodidum* and *hydrargyrum* should be administered.

If the disease is the result of overworking any set of muscles, these must be allowed a rest.

"The most effective remedy in wasting palsy is, undoubtedly, *galvanism*. Numerous observations attest its value when applied locally to the affected muscles" (Roberts).

I have seen improvement from the *faradic* current to the affected muscles, the strength being simply sufficient to produce contractions.

*Massage* is a valuable adjuvant to the electrical treatment, as are *hot sponging* and *rubbing* along the spine.

Prof. Bartholow "has apparently effected great improvement in a case, confined as yet to the left upper extremity, by the injection of glycerine solution into the wasting muscles."

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## CEREBRO-SPINAL NEUROSES.

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### CHOREA.

**Synonyms.** St. Vitus's dance; insanity of the muscles.

**Definitions.** A functional (?) disorder of the nervous system; characterized by irregular spasmodic movements of groups of muscles, with muscular weakness, more or less approaching paralysis of the affected parts.

**Causes.** Essentially a disease of childhood; hereditary; reflex from dentition, worms, masturbation or fright; probably the result of rheumatism in many cases.

**Pathological Anatomy.** As yet there has been no constant anatomical lesion discovered, the theory of emboli having, however, many advocates.

**Symptoms.** The onset is usually gradual, the child seemingly grimacing or jerking the arm or hand, as if in imitation, followed by decided, *irregular jactations* of the muscles of the face (histrionic spasm), of the eyelids (blepharospasm), eyeballs (nystagmus), and the shoulder, arm and hand, finally extending to the lower extremities, interfering with *motility*; in severe cases, inability of self-feeding or of holding anything in the hands. The *speech* is often unintelligible, the tongue constantly moving in an irregular manner.

The *heart's* action is tumultuous and irregular, associated with a soft, blowing, systolic murmur, most distinct at the base. The muscles are usually quiet during sleep, although this is not always the case. The mind is somewhat blunted, the temper irritable, the memory impaired. If the irregular muscular movements are confined to one side of the body it is termed *hemi-chorea*.

**Diagnosis.** Chorea was confounded with epilepsy until the points of distinction were pointed out by Sydenham.

*Paralysis agitans* has general muscular tremor, beginning in one limb, gradually progressing, uninfluenced by treatment; a disease of the elderly.

*Post-hemiplegic chorea* is the choreic movement of a paralyzed limb.

**Prognosis.** The vast majority of cases recover, but relapses are very frequent.

**Treatment.** Remove the cause, if possible. Easily assimilated diet. Many cases improve rapidly by confinement to bed in a darkened room. If the muscular movements interfere with sleep, *morpheina* or *chloral* are indicated. Regulate the secretions.

*Arsenicum* is the most reliable remedy yet introduced for the treatment of chorea. It should be pushed to its first physiological effects, then gradually reducing the dose until all symptoms disappear. The form of the remedy best adapted for administration in this disease is *liquor potassii arsenitis*, gtt. v, increased to gtt. x, or even gtt. xv, three times a day. *Extractum cimicifugæ fluidum*, m<sub>xx</sub>-3j, t. d., is serviceable, especially in cases following a rheumatic attack. Cases resisting the arsenicum treatment may succumb to *hyoscyamine*, gr.  $\frac{1}{200}$ - $\frac{1}{100}$ , three times daily. A patient of mine, aged 16 years, that resisted all the remedies mentioned, was promptly

cured by *antipyrine*, gr. x, 4 times daily. This same case in a former attack was arrested by *morphinæ sulphas*, gr.  $\frac{1}{4}$ , four times daily, but this latter remedy failed in the attack controlled by the antipyrine. If anaemia be present, combine or alternate *arsenicum* with *ferrum*.

## EPILEPSY.

**Definition.** A chronic disease, of which the characteristic symptoms are a sudden loss of consciousness, attended with more or less general convulsions.

**Causes.** Heredity; rarely, worry, anxiety, depression or fright. Pressure from a tumor at the periphery, or thickening of the membranes of the brain, causing pressure; dyspepsia (?); syphilis; uterine diseases.

**Pathological Anatomy.** There are no constant anatomical lesions, as yet, associated with epilepsy.

**Varieties.** I. *Epilepsia gravior*, le grand mal; II. *Epilepsia mitior*, le petit mal.

**Symptoms.** *Le grand mal* is preceded by a more or less pronounced and curious sensation, the so-called *aura epileptica*.

The attack proper is sudden, the subject suddenly falling, with a peculiar cry, loss of consciousness, and pallor of the face, the body assuming a position of tetanic rigidity, succeeded after a few moments by more or less pronounced clonic convulsions, followed by a coma of several hours' duration. The subject awakens with a confused or sheepish expression, with no knowledge of what has occurred, unless he has injured himself during the attack, either by the fall, or, what is very common, has bitten his tongue during the convulsions.

*Le petit mal* is manifested either by attacks of vertigo, the consciousness being preserved, or by a passing absent-mindedness, either form being associated with slight convulsive phenomena, followed by coma of short duration.

The mental functions are not, as a rule, injured by attacks of epilepsy, unless they recur very frequently. Indeed, when at wide intervals, the subject seems relieved by them, "the sudden, excessive and rapid discharge of gray matter of some part of the brain on the muscles," the so-called "electrical storm," having cleared the cerebral atmosphere.

**Diagnosis.** *Uræmic convulsions* closely resemble an epileptic

attack; but the dropsy or general oedema and albuminous urine of the former should guard against error.

Feigned epilepsy often misleads the most practical expert.

**Prognosis.** The vast majority of cases will not recover under treatment, but have the frequency and severity of the attacks greatly ameliorated, but sooner or later returning with their former severity. Cases the result of the various reflex causes usually recover when the cause is removed.

**Treatment.** To avert an impending attack, inhalations of *amyl nitris*, gtt. iij-v, a few whiffs of *chloroformum*, or the hypodermic injection of *morphina*.

To prevent the return of attacks, remove the cause if possible; attention to the secretions, and the internal administration of *potassii bromidum* in doses sufficient to abolish the faacial reflex and produce the symptoms of bromism, has great power in diminishing the severity and frequency of the attacks; better results are sometimes obtained by the combination of the various bromides. Cases in which the bromides are not serviceable are sometimes benefited by *argenti nitras*, *belladonna*, or *cannabis indica*. Weak and anaemic subjects usually do better with *strychnina* in full doses than with *potassii bromidum*. If a history of syphilis can be obtained, the combination of *potassii iodidum* and *potassii bromidum* will effect a cure.

Whichever of the above remedies are beneficial in any particular case, the permanency of the relief can only be maintained by the continuation of the drug for at least two years after the last attack.

Gowers highly recommends the following in cases complicated with cardiac dilatation:—

R. Potassii bromid., . . . . .	gr. xx
Tinct. digital., . . . . .	m. x. M.
SIG.—Three times a day.	

Another good combination is the following:—

R. Potassii bromid., . . . . .	gr. xv
Sodii bromid., . . . . .	gr. xv
Liq. potassii arsenit., . . . . .	m. ij
Ext. conii fd., . . . . .	m. ij
Aq. cinnamomi . . . . .	3j
Inf. gentian comp., . . . . . ad	3ss.

SIG.—Two hours after meals.

Brown-Séquard's mixture for epilepsy is as follows :—

Rx.	Potassii iodidi,	8 parts.
	Potassii bromidi,	8 "
	Ammonii bromidi,	4 "
	Potassii bicarb.,	5 "
	Inf. columbo,	360 "

Sig.—One teaspoonful before meals and three dessertspoonfuls on going to bed.

Prof. Da Costa has used with success a bromide of *nickel* in cases that have withstood the other combinations of the bromides.

## HYSTERIA.

**Definition.** A functional disorder of the nervous system, of the nature of which it is impossible to speak definitely; characterized by disturbances of the will, reason, imagination and the emotions, as well as motor and sensory disturbances.

**Causes.** A morbid condition confined almost exclusively to women. Young girls, old maids, widows and childless married women are the most frequent subjects of the disorder. The paroxysms frequently develop during the menstrual epoch. The menopause is another frequent period for its manifestation. A peculiar condition of the nervous system, either inherited or acquired, is responsible for the phenomena of hysteria, the peculiar manifestations being excited by disturbances of either the sexual, digestive, circulatory or nervous systems.

Hypochondriasis, a peculiar mental condition, characterized by inordinate attention on the part of the patient to some real or supposed bodily ailment or sensation, as seen in males, is a condition much like the hysteria of the female.

**Pathogeny.** Structural alterations have thus far not been detected in cases of hysteria; it is thus a functional disturbance of the nervous system. It should, however, be borne in mind that hysterical manifestations frequently develop during the prevalence of organic diseases.

**Symptoms.** These will be considered under the headings of the *hysterical paroxysm* and the *hysterical state*.

The Hysterical Paroxysm or Fit occurs nearly always in the presence of others, and develops gradually with *sighing*, *meaningless*

*laughter, causeless moaning, nonsensical talking and gesticulations,* or a condition of *fidgets*, followed with a sensation of *choking, dyspnoea* and a ball in the throat, the *globus hystericus*. These and similar symptoms precede the fit, during which the *unconsciousness is only apparent*, the patient being aware of what is transpiring about her. During the paroxysm the patients may struggle violently, throwing themselves about, their thumbs turned in and their hands clenched. Again, spasmodic movements occur, varying from slight twitching in the limbs to powerful general convulsive movements to almost tetanic spasms.

The paroxysm ends by sighing, laughing, crying and yawning, and a sensation of exhaustion. During the attack it will be noted that the surface and face are normal, showing absence of respiratory embarrassment, the breathing varying from very quiet to spluttering and gurgling sounds, the pupils not dilated, the pulse normal, the temperature normal, and absence of foaming at the mouth and wounding of the tongue.

The Hysterical State is shown by disturbances of the *mental, sensory-motor* functions respectively. It may be a permanent condition or occur at intervals with greater or less severity.

*Mental disturbances.* The patients are emotional, erratic, excitable, impatient and self-important, showing marked defects of will and mental power.

*Sensory disturbances.* This is either a condition of exaggerated sensibility or hyperæsthesia, as shown by the marked effects from the slightest irritation and the cutaneous tenderness along the spine, or a condition of anæsthesia as shown by the apparent absence or recognition of pain after severe irritation, or a perverted sensibility as shown by the feeling of tingling, numbness and formication. Sensibility to heat or cold are often absent. There is great perversion of the special senses in many of the cases.

Charcot, referring to the ovarian hyperæsthesia of hysteria, says : "It is indicated by pain in the lower part of the abdomen, usually felt on one side, especially the left, but sometimes on both, and occupying the extreme limits of the hypogastric region. It may be extremely acute, the patient not tolerating the slightest touch ; but in other cases pressure is necessary to bring it out. The ovary may be felt to be tumefied and enlarged. When the condition is unilateral, it may be accompanied with hemianæsthesia, paresis, or contracture

on the same side as the ovariangia ; if it is bilateral, these phenomena also become bilateral. Pressure upon the ovary brings out certain sensations which constitute the *aura hysterica*, but firm and systematic compression has frequently a decisive effect upon the hysterical convulsive attack, the intensity of which it can diminish, and even the cessation of which it may sometimes determine, though it has no effect upon the permanent symptoms of hysteria."

*Motor disturbances.* These phenomena embrace every variety of motor disturbance, from exaggerated excitable movements to defective or complete loss of power. With the paralysis that may occur, neither nutrition nor sensation are impaired. Hysterical paralysis is liable to frequent and sudden changes, the loss of power often disappearing suddenly. Aphonia, from paralysis of the laryngeal muscles, is a frequent form of paresis. Some hysterical patients refuse to even make an attempt at speech.

"A curious enlargement of the abdomen is observed sometimes, constituting the co-called *phantom tumor*. This region presents a symmetrical prominence in front, often of large size, with a constriction below the margin of the thorax and above the pubes. The enlargement is quite smooth and uniform, soft, very mobile as a whole from side to side, resonant but variable on percussion, and not painful. Vaginal examination gives negative results, and under chloroform the prominence immediately subsides, returning again as the patient regains consciousness."

Among the numerous other symptoms that may develop in a hysterical patient are *disturbances of digestion, the circulation, the respiration, disorders of micturition and menstrual disorders.*

Among other phenomena that belong to the Hysterical state are to be mentioned *Hystero-epilepsy*, a condition of hysteria to which is superadded the convulsion, epileptic in form; *Catalepsy*, a condition in which the will seems to be cut off from certain muscles, and in whatever position the affected member is placed, it will so remain for an indefinite time. There may or may not be unconsciousness and loss of sensation; *Trance*, the individual lying as if dead, circulation and respiration having almost ceased; *Ecstasy*, a condition in which the individual pretends to see visions and acts in the most ridiculous manner.

**Diagnosis.** The hysterical state is so general in its manifestations that it is to be borne in mind in diagnosing all ailments occurring in

woman. The diagnosis is attended with great difficulty, however, and requires the display of all the skill of the clinician to prevent error.

**Prognosis.** Death from either a hysterical fit or the hysterical state is the rarest of events, if it ever occur. The ultimate recovery of a hysterical patient is of frequent occurrence. Marriage has cured many cases, although it can hardly be advised by the physician.

**Treatment.** For the hysterical fit little need be done, as a rule, unless the paroxysm is violent or prolonged, in which case *ammonii valerianate*, *Hoffman's anodyne* or *spiritus ammoniac aromaticus* may be administered. Charcot recommends the making of firm pressure over the ovarian region to check hysterical fits that are of a severe character.

The management of a confirmed case of hysteria will tax the skill of the most astute physician. It is in connection with hysteria that the peculiar phenomena supposed to arise from applying different metals to the surface of the body have been noticed.

Moral and hygienic measures are of the first importance in the management of an hysterical patient. The treatment by *isolation* of hysterical patients is strongly urged by many specialists. Dr. S. Weir Mitchell has devised a plan for bedfast hysterical patients, of massage, faradization and forced feeding, which is successful in a fair number of cases.

There is no fixed therapeutical treatment for hysteria, the various symptoms calling for interference as they arise. It is well, however, to avoid the use of stimulants, opiates and chloral.

## NEURASTHENIA.

**Synonyms.** Spinal irritation; nervous prostration; nervous exhaustion.

**Definition.** A debility of the nervous system, causing an inability or lessened desire to perform or attend to the various duties or occupations of the individual.

Prof. Bartholow describes it as consisting "essentially in an exaggerated susceptibility to bodily impressions and false reasoning thereon."

**Causes.** It may result from various chronic diseases; mental worry or emotion; overwork, as "whenever the expenditure of nerve-force is greater than the daily income, physical bankruptcy sooner

or later results" (Jackson). Neurotic temperament; sexual excesses; alcohol; tobacco.

**Symptoms.** Nervous debility may affect any organ of the body. It is a condition of nerve-tire or exhaustion, and hence the nervous energy necessary for functional activity of any particular organ is wanting, a fair example being seen in cases of nervous dyspepsia.

One of the earliest manifestations of nervous exhaustion is an irritability or weakness of the mental faculties, as shown by inability to concentrate the thoughts, and efforts to do so causing headache, vertigo, restlessness, fear, a feeling of weariness and depression, together with the army of symptoms attendant on nervousness.

There may be ocular disturbances, cardiac palpitation, coldness of the hands and feet, chilliness followed by flashes of heat, followed in turn by slight sweating. Patients are troubled with insomnia, or fatiguing sleep accompanied with unpleasant dreams.

In the male there are genito-urinary disorders with pains in the back giving the dread of impotence. In females, painful menstruation, ovarian irritation and irritable uterus.

**Diagnosis.** It is of importance to determine between a true nervous exhaustion, and nervous debility the result of organic disease. A study of the history of the case, together with the symptoms, should prevent error.

**Prognosis.** Unless there be a tendency to mental disorders the prognosis is good.

**Treatment.** Attention to the secretions, diet and surroundings. Rest and diversion of mind is essential to success. Travel, short of fatigue, pleasant companionship, and relief from responsibility. Bathing, massage and galvanism are important aids to the management of cases.

Among the internal remedies that are of benefit may be mentioned, *arsenicum*, *strychnina*, *ferrum*, *zinci valerianate*, *phosphorus*, *extractum cocæ fluidum*, *vinum cocæ* and *syrupus hypophosphitis comp.*

## EXOPHTHALMIC GOITRE.

**Synonyms.** Grave's disease; Basedow's disease.

**Definition.** A disease of the nervous system; characterized by protrusion of the eyeballs, enlargement of the thyroid gland, dilatation of the arteries and palpitation of the heart.

**Causes.** An undemonstrative condition of the nervous system, either inherited or acquired, is the predisposing cause of Grave's disease. Among the exciting causes are, anaemia, shock, fright, chagrin, worry and reverses of fortune.

It is more common in women than in men.

**Pathological Anatomy.** "Some structural alterations have been found, in a majority of cases, in the sympathetic ganglia, and especially in the inferior ganglia." (Bartholow.) The veins and arteries of the thyroid gland are dilated, the result of a vasomotor paralysis. The enlargement of the gland is the result of the dilated vessels, a serous infiltration of its tissues, followed, if long continued, by hypertrophy. A considerable increase of fat behind the eyeballs has been observed. In the majority of cases more or less anaemia exists.

**Symptoms.** The development of the quartanary of symptoms may occur suddenly, the result of some great shock to the nervous system, but in the majority of instances the symptoms develop slowly and insidiously, with *cardiac palpitation*, with paroxysms of more marked acceleration, the pulse rate varying from 90 to 120, 150 and rarely as high as 200 beats per minute; soon *pulsations* of the vessels of the neck and thyroid gland may be felt and seen. The *enlargement* of the *thyroid gland*—the goitre—appears gradually after the development of the circulatory disturbances, although rarely it may be the first symptom observed. The goitre is elastic, rather soft, and has a *thrill* similar to an aneurism. The degree of enlargement varies in different cases, and in none ever attains a very great size. Following the development of the goitre occurs the *protrusion of the eyeball*—the exophthalmus—which may be confined to one eye, but usually occurs in both. Prominence of the eyeball may be the first symptom observed, but usually it does not develop until after the appearance of the goitre. The degree of protrusion varies from a slight staring expression to a point so great that the eyelids cannot cover the balls. Associated with the protrusion of the eyeballs is incoördination in the movements of the eyelids and the eyeball, the diagnostic rule of Graefe, so that when the eyes are quickly cast down the eyelids do not follow them, the sclerotic being visible below the upper lid. Vision is unimpaired. Conjunctivitis may arise, the result of the imperfect protection of the protruding ball by the eyelids.

Associated with the pathognomonic symptoms are nervousness,

irritability of temper, headache, insomnia, vertigo, fits of despondency, aphonia and cough the result of pressure of the goitre, disorders of digestion, increase of temperature, anaemia and loss of flesh.

**Diagnosis.** The fully developed disease presents no difficulties in diagnosis, but during its incipiency, before the characteristic symptoms have appeared, the disease may be confounded with such conditions as cardiac disease, neurasthenia, lithæmia, malaria, or incipient phthisis.

**Prognosis.** Recovery occurs in a fair number of cases, but is slow and tedious. The disorders of the circulation lead to dilated heart in many cases, and ultimately death occurs from this cause. Relapses are frequent.

**Treatment.** One of the first injunctions to be placed on a case of exophthalmic goitre is *rest*, both physical and mental, as well as freedom from worry or emotional excitement; little progress will be made if this point be neglected. The general nervousness, restlessness and insomnia will often call for special treatment, when use may be made of *chloral*, *potassii bromidum* or *sulphonial*; it is better, however, not to use this class of drugs in a routine manner, but for the special indications.

The chief indication, next to rest, is the condition of the circulation. To control this two remedies are of inestimable value, they are *digitalis* and *strophanthus*. The results I have seen from *tinctura strophanthus*, m.v from three to six times daily, have been most satisfactory. Dr. Bartholow "has had good effects from quinina, belladonna and ergotin, in combination."

The associated anaemia is to be treated by *ferrum*, *arsenicum* and an easily digestible and nutritious diet. *Galvanism* to the cervical sympathetic and pneumogastric is an important adjuvant to the medicinal treatment.

## DISEASES OF THE NERVES.

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### NEURITIS.

**Definition.** An inflammation of the nerve trunks; characterized by pain and paresis of the parts supplied by the affected nerve trunk.

**Causes.** Wounds and injuries; cold and damp.

**Pathological Anatomy.** Hyperæmia, followed by exudation into the nerve, "which becomes softened and ultimately breaks down into a diffluent mass." Migration of white corpuscles takes place into the neurilemma. Recovery may occur before destruction of the nerve elements is produced, absorption of the exudation occurring. "It is important to note that when inflammation occurs in a nerve it may extend from the point first diseased upward (*neuritis ascendens*), or downward (*neuritis descendens*)."

**Symptoms.** The onset may be accompanied with *febrile reaction*. The most decided symptom is *pain* along the course of the nerve trunk and its peripheral distribution, of a *burning, tingling, tearing, intense* character, increased by pressure or motion. If the affected nerve be a mixed one—sensory and motor—*spasmodic contractions* and *muscular cramps* occur, followed by impaired motion, terminating in *paresis* of the muscles innervated by the affected trunk.

If the inflammation proceed to destruction of the nerve trunk, wasting and degeneration of the muscular tissue ensues. Various trophic changes also occur, such as cutaneous eruptions, and clubbing of the nails. The *electro-contractility* is impaired or lost.

**Diagnosis.** Myalgia or muscular pain is not associated with paralysis, nor does the pain follow the course of a nerve trunk.

**Prognosis.** Generally favorable, with proper treatment.

**Treatment.** Repeated *blistering* along the course of the nerve, with full doses of *potassii iodidum* are usually successful. As the more acute symptoms subside the use of *galvanism* or a feeble, slowly interrupted *faradic* current restores the interrupted function.

For the pain and muscular contractions, hypodermic injections of *morphina*.

## NEURALGIA.

**Definition.** A disease of the nervous system, manifesting itself by sudden pain of a sharp and darting character, mostly unilateral, following the course of the sensory nerves.

**Varieties.** I. *Neuralgia of the fifth nerve*; II. *Cervico-occipital neuralgia*; III. *Cervico-brachial neuralgia*; IV. *Dorso-intercostal neuralgia*; V. *Lumbo-abdominal neuralgia*; VI. *Sciatica*.

**Causes.** Heredity; anaemia; malaria; syphilis; metallic poisons; anxiety; mental exertion; exposure to cold and damp; injuries of a nerve trunk.

**Pathological Anatomy.** The old axiom of neuralgia being "the cry of the nerves for pure blood" is perhaps only part of the truth. The changes in the nerve trunks or centres have not as yet been determined. A fair number of cases present the changes of neuritis.

### NEURALGIA OF THE FIFTH NERVE.

**Synonyms.** Tic-douloureux; Fothergill's disease.

**Symptoms.** *Paroxysmal pain*, of a sharp, darting, stabbing character, most common at points along the course of the supra- and infra-orbital branches of the fifth nerve of the left side, attended with increased lachrymation. When of any duration nutritive changes are observed in the nervous distribution, to wit: œdema along the course of the nerve, gray eyebrows and convulsive twitches of the muscles, termed "*tic douloureux*," tenderness at the infra- and supra-orbital foramina, as well as along the course of the nerve distribution.

### CERVICO-OCCIPITAL NEURALGIA.

**Symptoms.** *Paroxysmal pain*, of a sharp and lancinating, or deep, heavy, tensive character, along the course of the occipital nerve upon one or both sides, extending from the vertex and on the neck as far down as the clavicle, and upward and forward to the cheek. May be associated with *hyperæsthesia* of the skin, and with *cramps* in the cervical muscles, and with attacks of *herpes*. A sensation of cracking at the nape of the neck is an annoying symptom in many cases.

### CERVICO-BRACHIAL NEURALGIA.

**Symptoms.** *Paroxysmal pain*, of a severe, boring, burning or tensive character, with sensations of numbness and weakness of the

arm, hand, shoulder, scapula and mamma, with tenderness along the cervical plexus. *Œdema* of the arm and other parts along the distribution of the cervical plexus occur if the neuralgia be of long duration, the result of nutritive changes, the limb at times becoming pale, the skin glossy, dry and harsh.

#### DORSO-INTERCOSTAL NEURALGIA.

**Symptoms.** *Paroxysmal pain* of a sharp and lancinating character, along the fifth and sixth intercostal spaces, often associated with the development of herpes, the so-called *herpes zoster*, or "shingles."

Tenderness at the points where the nerves emerge from the intervertebral foramina at the sides of the chest and at points in front.

#### LUMBO-ABDOMINAL NEURALGIA.

**Symptoms.** *Paroxysmal pain* of a sharp and lancinating, at times heavy and dull character, following the course of the ileo-hypogastric nerve, ileo-inguinal and external spermatic nerve, supplying the integument of the hip, the inner side of the thigh, the scrotum and labium.

#### SCIATICA.

**Definition.** Pain following the course of the sciatic nerve. The sacral plexus is made up of the fourth and fifth lumbar and the first two pairs of sacral nerves.

**Symptoms.** Sciatica usually follows an attack of lumbago, the pain becoming fixed in the sciatic nerve; at times it is a true neuritis. *The pain is sharp*, tearing, shooting or lancinating in character, increased upon motion, shooting along the course of the nerve into the hip, inner side of the thigh, half of the leg, ankle and heel, at one or all of these points, in paroxysms lasting from a few hours to twenty-four hours or longer. The tactile sensation in the foot and motility in the limbs are impaired, and if of long duration, wasting of the limb occurs.

**Diagnosis.** *Rheumatism*, so-called, is the only condition likely to be confounded with neuralgia.

The history of the attack, the character of the pain, with its localized spot of tenderness, should prevent such an error.

**Prognosis.** If promptly and properly treated, unless the result of pressure of an exostosis, aneurism or other tumor, favorable.

**Treatment of Neuralgia.** Rest; easily assimilated but nutritious diet; removal of the cause, if possible. If anaemic, *ferrum* and *arsenicum*. If rheumatic, *alkalies*. If syphilitic or the result of metallic poisons, *potassii iodidum*. If malarial, *quinina*.

For an attack, *morphina* and *atropina*, hypodermically, afford the most prompt and ready relief.

Success usually follows the use of the well-known "Gross (Prof. S. D.) neuralgic pill":—

R.	Quininæ sulphas, . . . . .	gr. ij	
	Morphinæ sulphas, . . . . .	gr. $\frac{1}{2}$ ij	
	Strychninæ, . . . . .	gr. $\frac{1}{10}$	
	Acidi arseniosi, . . . . .	gr. $\frac{1}{2}$ ij	
	Extracti aconiti, . . . . .	gr. $\frac{1}{2}$	M.

Ft. pil. No. I.

SIG.—One every one, two or three hours.

Few attacks of trigeminal neuralgia will resist the following powerful prescription:—

R.	Aconitinæ (Duquesnel), . . . . .	gr. $\frac{1}{10}$	
	Glycerini,		
	Alcoholis, . . . . .	aa . . . . .	3j
	Aqua menth. pip., . . . . .	ad . . . . .	3ij.

SIG.—Teaspoonful repeated from four to eight times daily, carefully watching.

*Facial neuralgia* is often wonderfully benefited by the internal administration of *ext. gelsemii fld.*, gtt. iij-v, every three or four hours, until its physiological effects are produced. Excellent results often follow the administration of *Moussette's pills* (aconitine and quinimum).

For sciatica, antipyrine, gr. xx, repeated two or three times daily, has given relief. The deep injection of chloroformum is recommended by Bartholow. A spray of chloride of methyl along the course of the nerve for a few moments, watching the skin, will relieve the distressing pain. Rarely full doses *potassii iodidum* with a blister along the course of the nerve gives relief.

All forms of neuralgia are more or less benefited by—

R.	Quininæ sulph., . . . . .	gr. ij	
	Ferri redact., . . . . .	gr. j	
	Acid arsenious, . . . . .	gr. $\frac{1}{10}$	
	Aconitiæ, . . . . .	gr. $\frac{1}{10}$	M.

In pill every four or five hours.

The following formulæ of Bardet is highly recommended for all varieties of neuralgia :—

R. Exalgine, . . . . .	5 j
Spts. rect., . . . . .	1 x
Aq. destit., . . . . ad	2 v.

SIG.—One to three tablespoonfuls during the twenty-four hours.

## FACIAL PARALYSIS

**Synonym.** Bell's palsy.

**Definition.** An acute paralysis of the seventh cranial or facial nerve, the great motor nerve of the muscles of the face—the *nerve of expression*.

**Causes.** Exposure to a current of cold air against the side of the face—over the *pes anserinus*—is the most frequent cause. Also due to injury or disease of the middle ear. Syphilis.

**Symptoms.** The facial nerve supplies the muscles of the face, the muscles of the external ear, also the stylo-hyoid, posterior belly of the digastric, the platysma, one muscle of the middle ear the stapedius, and one palate muscle, the levator palati; by means of the chorda tympani branch it controls the secretion of the parotid and submaxillary glands, and, possibly, the sense of taste. It also furnishes motor power to the azygos uvulae, the tensor tympani and the tensor palati muscles.

The onset is usually sudden, with *tingling of the lips and tongue*, and upon looking into the mirror the patient is surprised by the perfectly blank, motionless side of the face, the corner of the mouth is depressed, the eyelids open, the face drawn toward the well side, and with inability to expectorate, whistle or swallow.

Any of the muscles innervated by the nerve may participate in the paresis.

The *electro-contractility* is feeble or lost. The *reflexes* are abolished.

**Diagnosis.** Paralysis of the muscles of the face occurs in hemiplegia; the points of differentiation are the presence of cerebral symptoms and the normal reflex excitability.

Facial palsy with otorrhœa, imperfect hearing, obliquity of the uvula and loss of taste determine its origin within the aquæductus Fallopii.

It is the result of cold if the taste be normal and the uvula straight.

If other nerves are also involved the origin is central.

**Prognosis.** Favorable.

**Treatment.** If the result of cold and damp, diaphoresis with *pilocarpus*, or diuresis with *potassii acetas*, *vel iodidum*, and blisters in front of ear, and the use of *galvanism* to the affected muscles.

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## DISEASES OF THE BLOOD.

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### ANÆMIA.

**Synonyms.** Spanæmia ; hydræmia.

**Definition.** A deficiency of red corpuscles and albuminoid compounds—a poverty of the blood ; characterized by pallor and general weakness.

*Oligæmia* is a lessening in the amount of blood ; *Ischæmia* is a localized anæmia.

**Causes.** Predisposing and exciting.

**Predisposing.** Sex ; the female, pregnancy and menopause ; heredity.

**Exciting.** Deficient food, air or sunshine ; excessive work ; mental worry ; prolonged and frequent nocturnal emissions ; excessive nursing ; chronic intestinal catarrh ; Bright's disease ; malaria.

**Pathological Anatomy.** *Post-mortem*, the tissues are thin, shrunken and bloodless. If the anæmia has been of long duration, patches of fatty change are seen in the various organs. The blood has a brighter color, the result of diminution in the number of red corpuscles and the quantity of the hæmoglobin ; it is thinner than normal, and coagulates slowly and imperfectly, from diminution of the fibrino-plastic constituent.

**Symptoms.** *Pallor*, gums, tongue, ear and conjunctiva pale. *Muscular weakness*, inability for exertion. *Deficient appetite* and *impaired digestion*, attacks of *vomiting* the result of anæmia of the medulla oblongata. *Quickened respiration*, *irritable temper*, *vertigo* in the erect position, attacks of *swooning*, *hysteria*, and rarely *epilepsy*. *Irritable heart*, with soft *systolic basic murmurs* and attacks of hysteria. Nocturnal emissions in male and deficient menses in female. *Maras-*

*mus* in children. More or less general *œdema* of the eyelids and ankles. Long continued, symptoms of fatty changes in various organs, or gastric ulcer result.

**Diagnosis.** The symptoms of anaemia are so characteristic that an error is impossible; the cause of it, however, may be hidden.

**Prognosis.** Favorable if treated early. If protracted, results in more or less general symptoms of fatty degenerations or ulcer of the stomach.

**Treatment.** Remove the cause. Easily assimilated, blood-producing diet. Fresh *air*, *sunlight* and *exercise* short of fatigue. Purgatives with stomachic tonics, to promote digestion.

For the anaemia proper, *ferrum* in some form is the most valuable remedy, always remembering that it is not assimilated if the intestines and liver be torpid.

The following alterative tonic, known as Smith's (Dr. A. H.) "four chlorides," is frequently of value:—

R. Hydrargyri chloridi corrosivum, . . . . .	gr. j-ij
Liq. arsenici chloridi, . . . . .	fʒj
Tinct. ferri chloridi,	
Acidi hydrochlorici dil., . . . . .	aa . . . fʒ iv
Syrupi, . . . . .	fʒ iij
Aqua, . . . . .	ad . . . . . fʒ vj.
	M.

SIG.—One dessertspoonful in a wineglassful of water after each meal.

Cases of anaemia with weak stomach can take the following "iron lemonade" with ease:—

R. Tinct. ferri chloridi, . . . . .	fʒj
Acid. phosphor. dil., . . . . .	fʒ ij
Syr. limonis, . . . . .	fʒ jss
Aquaæ, . . . . .	fʒ ij.

SIG.—One teaspoonful well diluted.

## CHLOROSIS.

**Synonym.** Green sickness.

**Definition.** A pronounced anaemia, occurring in girls about the age of puberty.

**Causes.** Obscure; inherited; menstrual irregularities. Hammond maintains "that it is an affection of the nervous system, the blood changes being secondary."

**Pathological Anatomy.** The blood is deficient in red corpuscles, the volume of the fluid normal or nearly so. Rarely the mass of blood is increased. The body is well nourished and the subcutaneous fat well distributed. The organs are abnormally pale. The spleen, the lymphatics and the marrow of the bones are not affected in any manner.

**Symptoms.** The condition is associated with disorders of menstruation. The young girl experiences a *change of disposition*, becoming *morose and despondent*, or rarely *hysterical*.

"As respects the actual condition of the sexual organs, there are two forms of derangement which happen in chlorosis; there are the *amenorrhæic* form and the *menorrhagic* form." After an attack of menorrhagia or after the failure of the flow to appear, the changes occur. The complexion changes, *blondes* becoming pallid, waxy and puffy without œdema; *brunettes* becoming muddy and grayish in color, with bluish-black rings under the eyes. Weariness and fatigue upon the least exertion; the heart irritable, with shortness of breath. The appetite is vitiated, the digestion imperfect; attacks of gastralgia are frequent.

A not infrequent complication is *gastric ulcer*. Phthisis develops in those having the slightest predisposition.

**Prognosis.** As a rule, unfavorable, on account of the liability to grave complications. Those recovering are always liable to relapses.

**Treatment.** A generous, nutritious diet; fresh air; moderate exercise; change of scene; cheerful surroundings. *Ferrum* and *arsenicum* are of the greatest utility. A good combination is—

R. Ferri arseniatis,	gr. $\frac{1}{2}-\frac{1}{6}$	
Ext. nucis vomicæ,	gr. $\frac{1}{6}-\frac{1}{4}$	M.
Ft. pil. No. I.		

SIG.—After meals.

The following is *Blaud's* formula, so highly lauded by Niemeyer:—

R. Pulv. ferri sulph.,		
Potassii carbonat. puræ, .	aa . . . . .	3 ss
Tragacanthæ, . . . . .		q. s.
Ft. pl. No. xcvi.		

SIG.—One to three or four pills three times daily.

## PROGRESSIVE PERNICIOUS ANÆMIA.

**Synonyms.** Anæmatosis: essential anæmia: anæmia of fatty heart.

**Definition.** A pernicious, progressive form of anæmia, of unknown cause, resisting all treatment, and toward its termination associated with fever.

**Pathological Anatomy.** The blood is scanty and pale, with diminished red corpuscles, albuminates and fibrin, showing a very feeble tendency to coagulate. There is no increase in the white corpuscles.

The *marrow* in adult bones becomes foetal, red and adenoid, and contains microcytes; several other changes have occurred secondarily in the marrow.

Secondary to the anæmia, the heart, larger arteries and certain capillary tracts exhibit circumscribed or diffused fatty degeneration.

The liver, spleen, kidneys and stomach are decidedly anæmic, causing fatty changes in those organs. The skin may contain petechiae of a purplish or brownish tint, and internal hemorrhages are not infrequent; retinal hemorrhage is rarely wanting.

There is not much emaciation, though the pallor is pronounced.

**Symptoms.** It begins insidiously, with increasing *languor* and *pallor*, the *muscular weakness* compelling the patient to take his bed. *Cardiac palpitation*, *dyspnœa*, attacks of *syncope*, *œdema* and swelling about the ankles, with *petechial* spots scattered irregularly over the surface.

The appetite is wanting, and nausea and vomiting occur, associated with marked *dyspepsia* and persistent *diarrhœa*. As the disease progresses a remittent form of *fever* develops, the temperature frequently showing 102-104° F.

Disorders of vision are the result of the *retinal hemorrhage*. The cardiac sounds are feeble and associated with soft basic or anæmic murmurs.

**Diagnosis.** Progressive pernicious anæmia is distinguished from simple anæmia and chlorosis by the greater severity of the former. From leucocythemia by the normal-sized spleen and liver, and the absence of increase in the white corpuscles.

**Prognosis.** Unfavorable.

**Treatment.** Symptomatic.

## LEUCOCYTHEMIA.

**Synonyms.** Leucæmia ; white cell blood ; white blood ; anæmia splenica.

**Definition.** A condition in which there is an enormous increase in the number of white blood corpuscles. It may assume either a *splenic*, a *lymphatic*, or a *myelogenic* form, and is characterized by symptoms of pronounced anæmia.

**Causes.** The real cause and nature of the affection is unknown.

**Pathological Anatomy.** The *spleen* is increased in size, density and firmness ; the *lymphatic glands* all over the body also enlarge, but are soft to the touch, often fluctuating ; the *marrow of the bones* changes from its normal rose color to that of a greenish-yellow ; the *liver* also enlarges enormously. The *blood* is paler than normal, its specific gravity reduced from 1.055 to 1.040 or lower, and the *white corpuscles* increased in number and in size, the *red corpuscles* being lessened in number and size.

**Symptoms.** The onset and early progress of the disease is identical with that of simple anæmia, accompanied by *swelling* of the *abdomen* and a feeling of *fullness* and *pain* in the *splenic region*, due to enlargement of that organ.

In the *lymphatic variety*, enlargement of the glands in the groin, neck and axillary region are associated with the *great pallor*.

In the *myelogenic variety*, the bones, more particularly the ribs and sternum, are tender on pressure, the patient developing a waxy appearance.

In each variety the appetite is poor, the digestion feeble, the bowels loose, the patient easily fatigued, with cardiac palpitation, and dyspnoea, with *cœdema* of the eyelids and ankles. The urine is scanty and of high specific gravity—1.020-1.030.

**Diagnosis.** This should cause but little trouble if enlarged spleen, lymphatic glands and tender bones are associated with great pallor, and the characteristic appearance of the blood as demonstrated by a “puncture of the finger of the patient and receiving the blood on a piece of white linen or a lawn handkerchief, and placing by the side of it a similar stain of blood from a healthy subject. The full color of the latter contrasts strikingly with the stain of the former, which is hardly of a blood color and translucent.”

**Prognosis.** No case of recovery has yet been recorded. The average duration is between two and three years.

**Treatment.** Symptomatic. A combination of the following remedies with generous diet, fresh air, sunshine, pleasant surroundings, *oleum morrhuae* and the *hypophosphites* have at times seemed of temporary utility, to wit: *quinina*, *arsenicum*, *ferrum* and *ergota*.

### ADDISON'S DISEASE.

**Synonym.** Melasma supra-renalis.

**Definition.** "The bronzed-skin disease." Thus defined by Averbeck: "A well-marked constitutional disease, exhibiting itself locally as a chronic inflammation of the supra-renal capsules, but in its essence consisting in a peculiar anaemic condition, always tending toward death, which is characterized by intense development of pigment in the cells of the rete malpighii and in the epithelium of the mucous membrane of the mouth."

**Causes.** Uncertain. Tuberclse, scrofula and syphilis have each been given as the cause.

**Pathological Anatomy.** A low form of inflammation, terminating in degeneration of the supra-renal capsule. The blood is deficient in fibrin and red corpuscles, with a slight increase of the white corpuscles. Fatty degeneration of the heart and vessels has been observed in some cases.

"The most striking change during life—the abnormal pigmentation—is due to the deposition of granular pigment in the cells of the rete malpighii, in the papillary portion of the cutis, and even in the connective tissue corpuscles. No change occurs in the proper structure of the skin. Similar pigment deposits occur in the mucous membrane of the mouth, especially along the edges of the teeth."

"The disease of the supra-renal capsules excites an irritation of the vaso-motor system—the trophic system—which leads to the pigmentation."

**Symptoms.** The onset of the disease is insidious, with a feeling of extreme languor, muscular fatigue, asthenia, indigestion, anorexia, dyspnoea, cardiac palpitation, vertigo, melancholia and excessive drowsiness.

The surface is first pale, then changes to a hue like that of *melanæmia*, changing to *icteroid*, finally resembling the color of a mulatto,

and then to a *lustreless bronze*. These changes also occur on the mucous membrane of the lips, tongue, gums and mouth.

**Prognosis.** An incurable disease. Duration, a year or two.

**Treatment.** Symptomatic.

## HÆMOPHILIA.

**Synonyms.** Hemorrhagic diathesis; "bleeder's disease."

**Definition.** A congenital condition characterized by the habitual occurrence of hemorrhages.

**Cause.** Hereditary.

**Symptoms.** The *bleeding* appears about the period of first dentition, and consists of spontaneous *hemorrhages* from the mucous membrane of the nose, mouth, lungs, stomach, intestines, or genito-urinary passages, or in *perfect cases*, hemorrhages occur directly from the fingers, toes, lobes of the ears, back of the hands or arms, without any apparent change in the skin, and continue, in spite of the most powerful means, for days or weeks. *Traumatic hemorrhages* occur if an injury of any kind is sustained about the period of the development of the bleeding.

*Epistaxis* is the most common form of all those named.

As a result of the great loss of blood, the subject suffers from all the symptoms of profound anæmia.

**Diagnosis.** It is impossible to confound the "bleeder's disease" with any other affection.

**Prognosis.** Death is the usual termination within a few weeks from the time of its development, which may not be until adult life.

**Treatment.** Entirely symptomatic. It is claimed that "*potassii chloras*"—an ounce of a saturated solution three times a day—combined with *tinctura ferri chloridi*," will eradicate the constitutional tendency.

## SCORBUTUS.

**Synonym.** Scurvy.

**Definition.** A peculiar condition of malnutrition or anæmia, gradually developing upon a dietary deficient in fresh vegetable material; characterized by decided anæmia, debility, mental lethargy, petechiæ and a swollen and spongy state of the gums, with a tendency to bleed upon the slightest irritation.

**Causes.** The disease only occurs when fresh vegetable nutriment or some appropriate substitute has been for a time partially or completely withheld.

**Pathological Anatomy.** An undetermined derangement in the composition of the blood, with diminished proportion of the potash salts. Spleen enlarged. The tissues are wasted and present extravasations, due to either one of or the combined presence of the following conditions, to wit: liquid condition of the blood, allowing it to escape from the vessels, alterations in the walls of the vessels, or a vaso-motor paralysis.

**Symptoms.** General weakness, lassitude, indisposition to either mental or physical exertion. The skin is dry, rough and of a muddy pallor, the face pale and bloated. *Swelling and sponginess of the gums*, with great tendency to bleed and an exceedingly *offensive breath*. *Looseness of the teeth*, hemorrhages from mucous surfaces, and *extravasations of blood* within and beneath the skin. The *lips are pale*, which is in striking contrast to the *redness of the gums*; the eyes are sunken and surrounded by a dark blue circle.

Hemorrhages occur from the stomach, mouth, bronchial tubes, intestinal canal and vagina. The skin is dry and rough, resembling that of a plucked fowl. *Œdema of the face and ankles* not infrequent.

*Depression of the spirits* is characteristic. Palpitation and dyspnoea on exertion. Urine high colored, speedily becoming fetid.

The patient usually longs for *fresh vegetables and fruits*.

**Complications.** Dysentery. *Scorbutic dysentery* is a frequent complication. It may co-exist with typhoid and typhus fever.

**Prognosis.** Favorable, if early and properly treated.

**Treatment.** The chief indication is the assimilation of the alimentary principles needed for the healthy constitution of the blood and the invigoration of the system.

The juice of lemons, oranges and other fruits. Antiscorbutic vegetables, to wit: raw cabbage, cresses and raw potatoes, in conjunction with meats, milk and farinaceous food.

Improve the appetite and digestion by the use of *strychnina, quinina, mineral acids* and *bitter infusions*. *Potassii chloras*, locally, will relieve the oral symptoms.

## PURPURA.

**Synonym.** Hemorrhœa Petechialis.

**Definition.** An acute disease, characterized by purplish discolorations of the skin, the result of hemorrhages into the upper layers of the cutis and beneath the epidermis.

**Varieties.** *Purpura simplex*; *purpura hemorrhagica*; *purpura urticans*.

**Causes.** Not properly understood. It may occur at any age, but is especially frequent in children and elderly people. Its occurrence after the ingestion of certain articles of diet has been observed.

**Symptoms.** *Purpura simplex* is the mildest form of the affection, and is characterized by the sudden appearance of small, bright red spots—a cutaneous hemorrhage—most commonly on the legs, associated with slight lassitude, mild febrile reaction, and aching pains in the limbs. The hue of the spots rapidly fades to a purplish color and slowly disappears. Relapses are common.

*Purpura hemorrhagica* has in addition to the eruption of purpura simplex—the cutaneous hemorrhage—a flow of blood from the free surface of mucous membranes. The most common hemorrhage is *epistaxis*, slight or profuse. Other hemorrhages are *haematemesis*, *melæna*, *hematuria*, *haemoptysis*, *menorrhagia*, and also into the substance of the mucous membranes of the palate, cheeks and gums. This variety is associated with great debility and depression, moderate fever and disorders of digestion. Marked *anæmia* results from the hemorrhages.

*Purpura urticans* is a combination of *urticaria* and *purpura simplex*. It is characterized by “rounded and reddish elevations of the cuticle, resembling wheals, but which are not accompanied, like the wheals of urticaria, by any sensation of itching or tingling.” They are usually seated on the legs, thighs, breast and arms, and are interspersed with petechiae. They gradually form and subside within twenty-four or thirty-six hours. Relapses are frequent.

This variety is also associated with malaise, moderate fever, and pains in the limbs.

**Prognosis.** *Purpura simplex* and *purpura urticans* are favorable, but relapses are very frequent. *Purpura hemorrhagica* is always a grave disease, often proving fatal from exhaustion, or more rarely,

cerebral or pulmonary hemorrhage. Recovery occurs frequently, under judicious treatment.

**Treatment.** Rest and a concentrated nutritious diet, and the moderate use of stimulants, to combat the resulting anæmia.

The internal use of *oleum terebinthinæ* is one of the most reliable remedies for all forms of the disease. The following is an eligible formula :—

R.	Ol. terebinthinæ, . . . . .	fʒ ij
	Ol. amygdalæ express., . . . . .	fʒ j
	Tinct. opii deodorat., . . . . .	fʒ ss
	Mucil. acaciaæ, . . . . .	fʒ j
	Aq. lauro-cerasi, . . . . ad . . . .	fʒ ij.

M.

SIG.—One teaspoonful every three or four hours.

Among the other numerous remedies suggested, the most reliable have been *acidum sulphuricum dilutum* and *tinctura ferri chloridi*. Good results have followed *acidum carbolicum*, gtt. ij–ijj every three hours, in cases seen by the author, and a particularly persistent case was cured by full doses of *potassii iodidum*.

"If hemorrhages that are threatened come on with a strong pulse, flushed face, headache and excitement, *digitalis*, *quinina* and *ergota* are the approximate medicaments." (Bartholow.)

*Locally*, to arrest bleeding, astringents and either hot or cold water or ice.

## DISEASES OF THE SKIN.

### DISORDERS OF SECRETION.

#### SEBORRHœA.

**Synonyms.** Acne sebacea ; pityriasis ; tinea furfuracea ; dandruff.

**Definition.** A functional disorder of the sebaceous glands of the skin ; characterized by an excessive and abnormal secretion of sebaceous matter, forming upon the skin either as an oily coating, or in crusts and scales.

**Varieties.** *Seborrhœa oleoso* ; *seborrhœa sicca*.

**Causes.** In newly-born infants an increased secretion of sebaceous matter—the *vernix caseosa*—is a physiological process.

The origin of the disease is for the most part illly understood, anaemia being a factor in many cases.

**Pathology.** Seborrhœa is a functional derangement of the glands; if it be allowed to become very chronic, there occurs atrophy of the glands and follicles.

**Symptoms.** The affection may occur upon any portion of the body, its most frequent seat being, however, the *scalp* (*seborrhœa capitis* or *pityriasis capitis*), and next in frequency the *face* (*seborrhœa faciei*).

*Seborrhœa oleosa*; appears as an *oily, greasy coating* upon the skin, without hyperæmia, and not attended with itching. The secretion is of an oily character, the quantity at times being so great as to collect in minute drops of a clear, yellowish fluid upon the surface.

The most common seat for this variety is the *face*—*seborrhœa faciei*—and *nose*—*seborrhœa nasi*.

*Seborrhœa sicca*, consists in the formation of *dry, more or less greasy masses of scales or crusts of a grayish, yellowish, or brownish-yellow color*, having a strong tendency to adhere to the skin, and attended with *decided itching*. Occurring upon the *scalp*—*seborrhœa capitis*—it is a frequent source of *premature baldness*.

**Diagnosis.** *Seborrhœa capitis* may be mistaken for dry eczema, but the former is always a *dry* disease, while in eczema moisture has occurred at some period of the affection. The scales in seborrhœa are very abundant and pale; in eczema the scales are scanty and reddish, the parts irritated, infiltrated and thickened.

*Seborrhœa sicca* and *psoriasis* have many points of resemblance, whether occurring on the *scalp* or on the body. In seborrhœa the scales are minute or caked, grayish or yellowish in color, of an unctuous feel and usually uniformly diffused. In psoriasis the scales are very dry, abundant, thick, white, irregularly dispersed, with intervening healthy skin, and the *surface beneath the scales is always reddish and inflamed*. The clinical histories of the diseases are entirely different.

**Prognosis.** If properly treated, favorable, although the affection is obstinate to eradicate.

**Treatment.** The secretions require attention. If anaemia be present, *ferrum* and *arsenicum* are indicated. The following formula of Sir Erasmus Wilson, and lauded by Hebra, is valuable:—

R. Vini ferri, . . . . . f $\frac{2}{3}$  iss  
 Syr. simplex,  
 Liquor potassii arsenit., . . . . aa . . . . f $\frac{2}{3}$  ij  
 Aquæ destil., . . . . . f $\frac{2}{3}$  ij.

M.

SIG.—Teaspoonful three times a day, with meals.

Duhring recommends *calcii sulphid.*, gr.  $\frac{1}{10}$ - $\frac{1}{5}$ , several times daily. Local measures are the most important in seborrhœa. For *seborrhœa capitis* the following plan will usually be successful:—

The scales are to be thoroughly moistened with either *oleum olivæ*, *oleum morrhœæ*, or *adeps*, to facilitate their removal; it is best applied at night and the head covered with a flannel or other cap. As soon as the crusts are well soaked they should be removed by washing with soap and warm water, or equal parts of soap, glycerine and water, or the following will be found valuable:—

R. Saponis viridis (Hebra), . . . . . f $\frac{2}{3}$  iv  
 Spts. vini rect., . . . . . f $\frac{2}{3}$  ij.  
 Solve et filtra.

SIG.—Dilute and use as a soap-wash or shampoo.

The scalp is to be thoroughly cleansed of either of the above by again washing with warm water and then dried by means of soft towels. Then should be applied some oily or fatty substance depending upon the condition of the scalp.

If much irritation, either *vaseline* or *oleum amygdalæ expressum*. If no irritation be present, a stimulating preparation will be found of great benefit. Either of the following may be used:—

R. Tinct. cantharidis, . . . . . f $\frac{2}{3}$  ij  
 Tinct. capsici, . . . . . f $\frac{2}{3}$  ij  
 Ol. ricini, . . . . . f $\frac{2}{3}$  ij  
 Alcoholis, . . . . . f $\frac{2}{3}$  ij  
 Spts. rosmarini, . . . . . f $\frac{2}{3}$  j.

M.

—DUHRING.

Or—

R. Bismuthi subnitratis, . . . . . f $\frac{2}{3}$  j.  
 Ung. hydrargyri ammon., . . . . . f $\frac{2}{3}$  ij-iv  
 Ung. aquæ rosæ, . . . . ad . . . . . f $\frac{2}{3}$  j.

M.

The above should be repeated every day or two, as the symptoms may require, until a cure is effected.

The following combination is useful for dandruff:—

R.	Ammonii muriat., . . . . .	gr. x	
	Glycerinæ, . . . . .	f $\frac{2}{3}$ j	
	Aq. rosæ, . . . . .	$\frac{2}{3}$ v.	M.
SIG.—	Apply to head.		

The seborrhœa of other portions of the body are to be treated upon the same general principles.

### COMEDO.

**Synonyms.** Acne punctata nigra; black heads or worms.

**Definition.** A disorder of the sebaceous glands; characterized by retention in the excretory ducts of an inspissated secretion which is visible upon the surface as yellowish or whitish pin-point and pin-head-sized elevations, containing in their centre blackish points.

**Causes.** The true etiology is unknown. Among the causes assigned are, anæmia, menstrual disorders, urethral irritations, dyspepsia and constipation.

**Pathology.** Comedo is an affection of the sebaceous glands and ducts, consisting of an accumulation of sebum and epithelial cells in the glands and follicles, dilating the ducts to such an extent as to produce the point or elevation upon the surface. The obstructed gland may relieve itself, or it may continue distending until a papule is formed. The duct sometimes contains small hairs, and also the microscopic mite—*demodex folliculorum*—having a length of from  $\frac{1}{150}$  to  $\frac{1}{5}$  of an inch, and breadth of about  $\frac{1}{500}$  of an inch, which was at one time erroneously supposed to be the cause of the affection.

**Symptoms.** Essentially a chronic affection, observed for the most part on the face, neck, chest and back. Each single elevation or black-head or point is designated a *comedo*, or if a number, in the plural, as *comedones*.

Each comedo is small, varying from a pin-point to a pin-head in size, having a brownish or blackish appearance, from the dust or dirt that has adhered to their unctuous surface. If they form in great numbers upon the face they are disfiguring, giving the individual the appearance of having had minute grains of powder implanted in the skin. There is no evidences of inflammation unless acne is associated, but, on the contrary, the skin has a dirty, greasy, unwashed appearance.

**Diagnosis.** There is no condition resembling comedo, so that its recognition is easy, unless complicated with acne; but even then the inflammatory appearance of acne should prevent an error.

**Prognosis.** Favorable, although often remarkably obstinate.

**Treatment.** Derangements of any of the functions of the body should be corrected, and strict attention be given to the rules for promoting the general health.

*Local* measures are usually sufficient to promote a cure of the affection.

The parts affected should be thoroughly softened by bathing with soap and warm water, when the comedones are removed by friction with a Turkish towel, pressure between the thumb nails, the application of a watch key, or the instrument known as the "comedo extractor," and their return prevented by an *unguentum* medicated, to meet the indications, with either *sulphur*, *alkalies* or *hydrargyrum*.

Piffard's acne application I have found valuable :—

R. Sulphur sublim., Alcoholis, Tinct. lavend. comp., Glycerini, Aque camphoræ, . . . . . $\text{a}\ddot{\text{a}}$ . . . . . f $\ddot{\text{z}}$ j.	M.
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Sig.—Apply freely, after removal of the comedones.

### MILIUM.

**Synonyms.** Grutum ; tubercula miliaria or sebacea ; acne punctata albida.

**Definition.** An accumulation of sebum in the sebaceous glands which are minus their excretory ducts ; characterized by the formation of small, roundish, whitish, sebaceous, non-inflammatory elevations, situated immediately beneath the epidermis.

**Cause.** The origin of the affection is not understood.

**Pathology.** The sebaceous gland is distended with the sebum, which is unable to escape owing to the obliteration of the duct, nor can the contents be squeezed out, as no sign of aperture is to be found, the formation being completely enclosed.

Rarely the retained secretion undergoes a metamorphosis into hard, calcareous, stone-like masses—sebaceous concretions or *cutaneous calculi*.

**Symptoms.** Milia may occur upon any portion of the body; their usual seat, however, is upon the face, forehead, and about the eyes. They form gradually, are about the size of a millet seed, of a whitish, pearl or yellowish color, hard, and of a rounded shape, giving the sensation to the touch of hard bodies embedded in the skin. They are not associated with inflammatory symptoms.

**Diagnosis.** Milium and comedo are somewhat similar in appearance; the differences are that in milium the sebaceous gland is distended without an opening, while in comedo the duct of the gland is always patulous upon the surface. Milium usually exists singly, the skin looking normal; while comedo is more general, the surface having a soiled and greasy appearance.

**Prognosis.** Favorable.

**Treatment.** As a rule no treatment is needed, the number being few and their presence of no consequence.

If their removal be desirable, two modes suggest themselves; one, to open the cyst with a fine-bladed bistoury, and turning the contents out, destroying the remaining sack by the application of either *tinctura iodi* or *acidum chromici*; or, the cyst may be destroyed by *electrolysis*. If a tendency to recur is shown, the plan may be repeated.

## SEBACEOUS CYST.

**Synonyms.** Wen; sebaceous tumor; encysted tumor.

**Definition.** A distention of the sebaceous gland and duct, with hypertrophy of the walls, which forms a thick, tough sack or cyst; characterized by the appearance of a firm or soft, more or less rounded tumor, having its seat in the skin or subcutaneous connective tissue.

**Cause.** Unknown.

**Pathology.** Hypertrophy of the gland and duct walls, the result of pressure from the accumulated contents, which consist of the altered products of the sebaceous secretion.

**Symptoms.** The development of wens is slow and insidious. The localities where they are more commonly developed are the scalp, face, back and scrotum.

The tumors occur singly or in numbers, in size from a pea to a walnut, or larger, in shape either rounded, flattened or semi-globular; in consistency they are either hard or soft, and doughy; they are freely movable and painless.

**Diagnosis.** Sebaceous cysts may be confounded with fatty tumors.

**Treatment.** Excision and careful and thorough dissection of the cyst.

## HYPERIDROSIS.

**Synonyms.** Hydrosis; ephidrosis; excessive sweating.

**Definition.** A functional disorder of the sweat glands; characterized by an increased secretion of sweat. The sweating may be either general or partial.

**Causes.** Often undetermined; occasionally inherited; nervous derangements; malaria; diseases of the heart and lungs.

**Pathology.** A functional derangement of the sudoriparous glands, over which the vaso-motor system has control. The character of the secretion, chemically, may not differ from the normal.

**Symptoms.** Universal general sweating, such as occurs during the course of pneumonia, rheumatism, tuberculosis, typhoid and other febrile maladies, can hardly be considered a distinct affection.

*Hyperidrosis* may be acute or chronic, the amount slight or large, being constant or paroxysmal, the extent general or local, and it may or may not be symmetrical.

*Bromidrosis* is the designation when the secretion has an offensive odor.

*Chromidrosis* is the designation when the fluid poured forth is variously colored.

*Uridrosis* is the designation when the excretion from the sweat glands contains the elements of the urine and particularly urea.

*Phosphoridrosis* is the designation when the perspiration appears luminous in the dark.

*Local hyperidrosis* occurs most commonly upon the palms, soles, axillæ and genitalia.

Hyperidrosis of the palms may be so profuse that the fluid accumulates and keeps the parts constantly macerated, the wearing of gloves being impossible, for as soon as the parts are wiped dry they are again bathed in the secretion.

Hyperidrosis of the soles is a disagreeable and often distressing condition, as the socks and shoes become saturated, and thus keep the soles constantly bathed, allowing the macerated epidermis to peel off, leaving the more tender skin exposed, causing pain and distress

when walking. The maceration of the epidermis, the secretion about the toes, together with the moisture of the socks and the soles of the shoes, promote the rapid development of the *bacteria fætidum*; all these together produce a most disagreeable, disgusting and persistent odor, which is termed *bromidrosis pedum*.

Hyperidrosis of the genitalia attacks males more particularly, giving rise to a disagreeable, penetrating odor.

The sweating may be limited to one side—*unilateral hyperidrosis*.

**Prognosis.** The majority of cases are extremely intractable; complete recovery is rare in a fair proportion, while some cases are easily relieved.

**Treatment.** The general condition of the patient must receive proper attention.

*Local treatment* is the most valuable, however, in this affection.

The parts should be cleansed and immediately dried, and then dusted with some one of the numerous dusting powders. The following is a valuable powder:—

R. Acidi salicylat., . . . . .	gr. xx	
Zinci oleat., . . . . .	ʒj.	M.

Perhaps the very best local application is *tinctura belladonnae*, either diluted or full strength.

In hyperidrosis of the palms and soles, the following are valuable, first washing the parts with a weak solution of *acidum carbolicum*:—

R. Acidi salicylici, . . . . .	ʒ ss
Cretæ præp., . . . . .	ʒj.
Aluminis exsic., . . . . .	ʒj.

M. et powder finely.

SIG.—Apply to parts with puff ball.

Or—

R. Acid. salicylici, . . . . .	3 parts	
Pulv. amyli, . . . . .	10 parts	
Pulv. soapstone, . . . . .	87 parts.	M.

SIG.—Sift into shoes and stockings.

Or—

R. Ungt. picis liquidæ,	
Ungt. sulphuris, . . . . .	ʒj.

S.G.—Spread on cloth and applied with bandage. (WILSON.)

Or—

R. Potassii permanganat., . . . . . gr. ij  
 Aquæ destil., . . . . . f $\frac{2}{3}$ j. M.  
 SIG.—Frequently applied.

A saturated solution of *acidum boracicum* applied frequently to the hands and feet often proves curative.

For obstinate cases, involving the palms or soles, the following plan of treatment, as suggested by Hebra, will be found of the greatest service. It is imperative that the various steps be closely followed: "The parts are to be cleansed with water and soap, and the following ointment applied on pieces of cloth cut to the size of the region. Lint smeared with the ointment is also to be placed between the toes or fingers, so that every portion of the skin may be covered with a layer of the ointment.

R. Emplast. diachyli, . . . . .  $\frac{2}{3}$  iv  
 Olei olivæ, . . . . . f $\frac{2}{3}$  iv.

The plaster to be melted, and the oil added and stirred until a homogeneous mass results.

SIG.—To be used on cloths.

"The cloths are to be changed every twelve hours, when the parts are not to be washed, but rubbed dry with lint and starch dusting powder, after which new dressings are again to be applied in the same manner. This proceeding is to be continued from one to two weeks. When the disease is upon the soles, the patient may walk about in loose shoes." After a week or ten days the ointment can be discontinued, but the dusting powder is to be continued for a considerable period. If relapses occur, the original treatment should again be instituted.

### SUDAMINA.

**Synonyms.** Sudamen; miliaria crystallina (Hebra).

**Definition.** A non-inflammatory affection of the sweat glands; characterized by the rapid development of millet-seed-sized, translucent, whitish vesicles, in great numbers, upon any portion of the body.

**Cause.** A high temperature, causing unusual activity of the sudoriparous glands.

**Pathology.** The glands being excited beyond their capacity for normal excretion, the excessive fluid, instead of escaping upon the

surface, from some cause collects between the layers of the epidermis, in the form of minute, translucent, pin-point-sized vesicles.

**Symptoms.** Each minute vesicle is distinct, but they exist in great numbers, very closely resembling drops of free sweat. They develop rapidly, never coalesce, become puriform or rupture. Fresh crops form from time to time. Their duration is transitory; the fluid is absorbed, the covering of each dries, forming a thin, delicate membrane, which disappears as a slight desquamation.

**Treatment.** The treatment is that of the disease with which they occur.

### ANIDROSIS.

**Definition.** A functional disorder of the sweat glands; characterized by a diminished or insufficient secretion of sweat.

**Cause.** The result of a congenital deficiency of the sweat glandular apparatus. Local anidrosis may result from injury to a nerve, during the course of chronic diseases of the skin, as ichthyosis, eczema, psoriasis, lepra and elephantiasis arabum. In rare cases an individual ceases to sweat entirely at times; in such cases the general health is impaired, and during the hot season much suffering may ensue.

**Treatment.** Means to promote the activity of the skin and glands is the indication, such as the ingestion of large quantities of water, hot baths and steam baths, friction and the use of sudorifics, the most valuable of which is *pilocarpus*.

### HYPERÆMIAS OF THE SKIN.

#### ERYTHEMA SIMPLEX.

**Definition.** An acute affection of the skin, in which occurs an abnormal quantity of blood in the dermal vessels; characterized by discoloration, which disappears upon pressure and with more or less local increase of temperature.

**Varieties.** Idiopathic erythema; symptomatic erythema.

**Causes.** *Idiopathic erythema*; heat, cold, pressure, friction, or the contact of irritants, such as mustard, arnica and dyestuffs.

*Symptomatic erythema* occurs most frequently in childhood, from diseases of the stomach and intestines; during the course of the various exanthemata.

**Symptoms.** A more or less rapidly developed *redness* of the skin, varying in color from pink or light red to dark red, which *disappears upon pressure*, to rapidly return again. The extent and form of the congestion varies according to the cause, at times being as small as a coin and isolated, and again diffused over a large area. The temperature of the congested part is slightly above the normal.

Slight itching and burning are, usually, associated with the dis-coloration.

**Diagnosis.** Erythema resembles acute dermatitis in color, but the subjective symptoms of the latter are so decided that an error should not occur.

**Treatment.** Controlled by the cause, which should be removed, and the local application of some one of the various dusting powders.

### ERYTHEMA INTERTRIGO.

**Definition.** An acute congestion of the skin; characterized by redness, heat, increased perspiration, and an abraded surface, with maceration of the epidermis.

**Causes.** In the fleshy, from contact or friction of opposing surfaces exposed to warmth—chafing. In children and infants contact of moist clothing; also disorders of digestion.

**Symptoms.** Parts where the natural folds of the skin come in contact with one another, as the nates, perineum, groins, axillæ and beneath the mammae, in the fleshy and in infants, become *red, hot, painful*, and have an *increased flow of perspiration*, which in turn *softens the epidermis*, giving rise to an acrid mucoid fluid. If not checked by the removal of the cause and the application of the dusting powders, inflammation—dermatitis—results.

**Treatment.** The congested parts should be thoroughly washed with water and castile soap, or with bran-water, and carefully dried with a soft towel. The opposing folds of the skin are to be kept separated with lint or soft linen, the parts first covered with *cretæ præparata, zinci oxidum, bismuthi subnitras, amyrum, lycopodium or buckwheat flour.*

## INFLAMMATIONS OF THE SKIN.

## ECZEMA.

**Synonyms.** Tetter; salt rheum; scall.

**Definition.** A non-contagious inflammation of the skin, characterized by any or all of the results of inflammation at once or in succession, such as erythema, papules, vesicles or pustules, accompanied by more or less infiltration and itching, terminating in a serous discharge, with the formation of crusts, or in desquamation.

**Forms.** *Acute; chronic.*

**Varieties.** *Eczema erythematosum; eczema vesiculosum; eczema pustulosum; eczema papulosum; eczema rubrum; eczema squamosum; eczema fissum; eczema verrucosum; eczema sclerosum.*

**Cause.** Eczema attacks persons in all spheres, the rich, the poor, the infant or the aged, and males or females. Many families, especially those having the "catarrhal predisposition or peculiarity of constitution," seem more liable; indeed, it appears probable that a predisposition to eczema may be transmitted from parent to child. Among the causes suggested are: dentition, improper food, gastrointestinal disorders, intestinal parasites, deficient urinary secretion, the rheumatic and gouty diathesis, vaccination, prolonged contact of hot fomentations, heat and cold, and contact with the poison vine (*rhus toxicodendron*) and poison tree (*rhus venenata*).

**Pathology.** Eczema is a catarrhal inflammation of the skin—a dermatitis with superficial serous exudation. There is first *hyperæmia* or congestion of the vessels of the skin—*eczema erythematosum* when uniformly distributed, *eczema papulosum* when the congestion is limited to distinct points. The hyperæmia is soon followed by a *serous exudation*. If the superficial exudation be profuse enough to form small drops, and if the epidermis possess sufficient resisting power not to give way immediately before it, vesicles form, producing the variety known as *eczema vesiculosum*; if the vesicles contain a large admixture of young cells, so that the serum be turbid, yellow and purulent, the vesicles become pustules, termed *eczema pustulosum*; if the serous exudation be not sufficient to either elevate or break through the epidermis, instead of either vesicles or pustules forming there occur dry scales, rising from the reddened skin—*eczema squamosum*. When the exudation is sufficient to detach the epidermis, thus exposing the red and moist corium, it is termed *eczema rubrum*.

In chronic eczema the skin is sub-acutely inflamed; is very much thickened, hardened and infiltrated with cells which extend throughout the entire corium, even into the subcutaneous connective tissue. The papillæ are enlarged and at times may be distinguished with the naked eye. Pigmentation may take place in the deep layers of the rete, and in the corium, especially about the vessels.

**Symptoms.** Eczema is the most common of all cutaneous affections, with symptoms varying in accordance with the particular variety of the affection and its location, although the general characteristics of a catarrhal inflammation are present in all; these are *redness*, either limited or diffused, *heat* of the part affected, *swelling*, the result of the serous exudation, giving rise either to a *discharge* (weeping), with subsequent *crusting*, or to the deposition of plastic material. The most constant, annoying and troublesome symptom is the *itching*, or at times *burning*, which varies from that which is simply annoying to that which is almost unendurable.

Eczema runs its course either as an acute affection, lasting a few weeks, not to return, or to return acutely at wide intervals, or, as is much more frequently the case, it assumes a chronic state, continuing with more or less variation for months, years or even a lifetime. It may appear upon any portion of the body, or involve the whole integument (*eczema universale*). The varieties are named in the order which the lesions assume at its commencement.

**Eczema Erythematosum.** An *erythema* or *redness* of the surface, with a yellowish tinge. The size of the macule may be very small or quite extensive, with irregular outlines. There may be slight swelling of the patch, but no discharge occurs unless it be where two surfaces come into contact (*eczema intertrigo*), as about the genitalia. Cases without discharge are covered after a few days with a thin film of dry, exfoliating epidermis or scale (*eczema squamatum*). When a discharge (weeping) or moisture occurs, it is followed with more or less crusting.

*Intense itching* is a constant symptom.

**Eczema Vesiculosum.** Begins with *burning*, *pain*, *redness* and *swelling*, followed by an immense number of minute vesicles, either discrete or confluent, rapidly distending with a clear or yellowish fluid and attended with *intense itching*. Soon the vesicles rupture, the fluid rapidly diffusing over the surface and drying into yellowish, *honey-like crusts*. New crops of vesicles soon follow, or if subsequent

vesication do not occur, the fluid rapidly diffuses over the excoriated surface, which also, in turn, dries into large, yellowish crusts. After a variable time the various symptoms gradually subside.

*Itching* is the most prominent subjective symptom, is intense, and gives rise to an irresistible desire to scratch.

All portions of the body are liable to this variety of eczema, the most frequent location, however, being the face, and when occurring in children is commonly known as *crusta lactea*.

**Eczema Pustulosum, or Eczema Impetiginosum.** This variety usually begins as vesicular eczema, the fluid rapidly changing to pus. After a short period, during which the pustules have increased in size, they burst and the escaped fluid forms thick, greenish-yellow crusts, which, in turn, rapidly dry and fall off, or crumble away.

The location of this variety is most usually upon the scalp and face. It is stubborn to treatment. *Itching* is a prominent symptom.

**Eczema Papulosum, or Lichen Simplex.** This variety of eczema appears in the form of small, rounded *papules*, the size of a pin-head, of *bright* red, or at times *dark* red color; they may be either discrete or confluent. In some cases all, while in others a greater or less number of the papules pass into vesicles and run much the same course as vesicular eczema. The itching is of the *most intense* character, leading to severe scratching, by which the summits of the papules are torn, causing them to bleed, the blood forming dark red crusts.

**Eczema Rubrum, or Eczema Madidans.** This is a variety only from a clinical standpoint. It may result from any of the foregoing varieties. The surface of the skin is inflamed and infiltrated, *red, moist* and *weeping*, the profuse serum rapidly drying into thick, yellowish, greenish or brownish *crusts*, the color depending upon the character of the fluid, which may be serum, pus or blood from the exposed and lacerated corium. The crusts adhere closely and firmly to the part, and, unless removed by mechanical means, may remain indefinitely, the disease pursuing its course beneath.

*Eczema rubrum, or madidans*, "then, presents two appearances—as it occurs with its crust, and as it exists without this covering. In the one case the skin itself is altogether obscured by a dirty, yellowish or brownish crust; in the other the skin presents a bright or violaceous red, punctate, wounded surface, deprived in great part of its epider-

mis, and exuding a scanty or profuse, clear or opaque, syrupy, yellowish fluid. Sometimes this is streaked with blood." The *itching* and *burning* are severe. It may develop upon any portion of the body, but is most commonly seen upon the legs, particularly in elderly people. Its course is chronic and increasing in severity.

**Eczema Squamosum.** This is also a clinical variety. It results from the erythematous, vesicular, pustular or papular varieties of the affection, but more particularly the first named. A typical case presents itself in the form of variously sized and shaped reddish patches, which are dry, or more or less scaly, the skin being more or less infiltrated or thickened. Its course is usually chronic.

**Eczema Fissum, or Rimosum.** Another clinical variety. During the progress of the erythematous, vesicular or pustular varieties of eczema, *cracks* or *fissures* result when the lesion occurs upon regions subject to constant motion, such as between the fingers, toes and the various joints. At times the fissures are extensive and deep, and of a bright red color, showing the true skin, and intensely painful upon motion. Chapped hands are typical instances of fissured eczema.

**Eczema Sclerosum.** This variety of eczema, occurring most commonly on the palms, soles and finger-tips, is characterized by hypertrophy of the papillæ, showing itself as hard, thickened, infiltrated, localized patches, which are most apt to crack (eczema fissum).

**Eczema Verrucosum, or Papillomatosum,** differs from the foregoing in that the thickened, infiltrated patch has a *warty* verrucous appearance. Its course is chronic.

**Eczema Acutum et chronicum.** The line which divides these two conditions is drawn by means of the clinical and pathological features. The course of eczema, in the majority of instances, is chronic. It may be said that so long as the general inflammatory symptoms are high and the secondary changes slight, the affection is acute, and that when the process has settled itself into a definite line of action, continually repeating itself and accompanied by secondary changes, it is chronic.

**Diagnosis.** The many varieties in which eczema manifests itself renders the diagnosis a matter of importance. The following characteristic features of eczema are of value in arriving at a diagnosis: *inflammation, swelling and adema, thickening from cell infiltration, redness, the discharge or moisture, followed by crusting, on removal of which a moist surface is presented, and itching and burning.*

*Erysipelas* may be confounded with erythematous or vesicular eczema. The points of difference are the fever and other general disturbances, the deep-seated inflammation of the skin, rapidly spreading, with heat, swelling and œdema without moisture, giving the surface a deep red, shining and tense appearance, are characteristic of erysipelas and very different from eczema.

*Herpes* and vesicular eczema bear some resemblance to each other; herpes zoster is distinguished by the neuralgic pains which are associated with it and are never associated with eczema. The other varieties of herpes occurring about the face and genitalia run their course in a few days, while eczema is of much longer duration and has a discharge followed by crusting.

*Seborrhœa* of the scalp and squamous eczema of the same region closely resemble each other. In eczema, however, the skin is more or less red, inflamed and thickened, and the scales larger, less abundant and less greasy and drier than seborrhœa. In eczema the scales are usually seated upon a circumscribed patch, while in seborrhœa, as a rule, they cover the scalp uniformly. Itching occurs with both disorders. The history of the two affections should be of material aid to render the diagnosis clear; still, however, in many cases the difficulty is marked. Both are frequent affections.

*Psoriasis* should never be confounded with a typical case of eczema, but chronic eczema, with infiltrated, inflammatory, scaly patches, frequently looks very much like psoriasis.

**Treatment.** There is no specific. The indications are for the removal of the cause, where it can be ascertained, if it be possible, and attention to the general health. The diet should be of the most nutritious, but easily digestible character; fresh air and moderate exercise are also essential elements in the treatment, together with attention to the secretions. If the bowels be sluggish, much benefit follows the use of such laxative mineral spring waters as the Hathorn, or Hunyadi Arpad, or a morning dose of *magnesii sulphas*. For children, *syrupus rhei*, to which may be added *magnesia*; or what is perhaps more efficient, a small dose of *hydrargyri chloridum mite*. If the urinary secretion be small and the urine heavy, use should be made of full doses of *potassii acetas* and large draughts of water. If either a rheumatic or gouty disposition exist, *lithium* salts, to which may be added *vinum colchici seminis*. If a scrofulous tendency exist, use *oleum morrhuae* and *syrupus ferri iodidi*. If anaemia,

*ferrum, quinina, strychnina* and the mineral acids, or *syrupus hypophosphitis comp.*, are indicated.

*Locally* : the most important means of treatment for all the varieties of eczema are with local remedies, suiting the appropriate ones for each particular case, as no one combination is applicable for all varieties. It may be stated, as a principle, that nothing irritant is ever to be applied to the surface in acute eczema, and that in the chronic form nothing can hardly be too stimulating. The too frequent washing or general baths are to be avoided, as they have a tendency to macerate the already softened epidermis. For cleansing purposes, in the majority of instances, ordinary Castile soap is sufficient.

*Crusts and scales* are nearly always present in eczema, and are to be removed before medicaments can be successfully applied. Their removal is to be secured by saturation with oily preparations, a starch or other mild poultice, or a saturated solution of *acidum boracicum*. After their removal the parts are to be cleansed with Castile soap and water.

For acute *erythematous* or *vesicular eczema*, use but little, or what is better, no soap or water; instead, cover the parts with a dusting powder, such as—

R.	Pulv. camphoræ, . . . . .	ʒij	
	Zinci oleat., . . . . .	ʒij	
	Pulv. amyli., . . . . .	ʒij	M.
SIG.—Dusting powder.			

For acute *vesicular eczema*, Dr. J. C. White recommends bathing the affected part with *lotio nigra* (*hydrargyri chlor.* mite gr. viij, *liquor calcis fʒj*), full strength, or diluted with equal parts of lime water, applied by means of a sponge or a piece of cloth, for ten or fifteen minutes at a time, and at intervals of a few hours or longer, the sediment being allowed to remain on the skin; after which *ung. zinci oxid.* is to be gently rubbed over the part. As a rule, the itching and burning are relieved at once, and the affection often arrested. Good results follow the use of a saturated solution of *acidum boracicum*.

There are cases which do better from the application of ointments, of which the following is valuable :—

R.	Zinci oleat.,		
	Olei olivæ, . . . . .	aa . . . . .	ʒ iv.

Or, *bismuth oleate*, made according to the following formula of Dr. McCall Anderson :—

R.	Bismuthi oxidi,	ʒij	
	Acidi oleici,	ʒij	
	Ceræ albæ,	ʒij	
	Vaselini,	ʒix	
	Ol. rosæ,	mij.	M.

If the discharge be excessive, the following formula of Prof. Bartholow I have seen useful :—

R.	Plumbi acetat.,	ʒss	
	Pulv. camphoræ,	gr. xv	
	Ol. amygdal.,	fʒij	
	Cerat. flav.,	ʒj.	M.

The late Dr. Frank Maury was partial to the following formula in vesicular eczema :—

R.	Hydrargyri chlor. mite.,	gr. xx	
	Ung. zinci oxid. benz.,	ʒj.	M.

For *eczema papulosum* the following lotions are particularly valuable :—

R.	Acid. carbolici,	ʒij-ij	
	Glycerini.,	fʒiv	
	Alcoholis.,	fʒiv-vj	
	Aquaæ destil.,	ad Oj.	M.

—DUHRING.

Or—

R.	Thymol.,	gr. x-xx	
	Alcoholis.,	fʒj	
	Aquaæ destil.,	fʒj	M.

After the disappearance of the more acute symptoms, more stimulating applications are indicated, among which are *acidum carbolicum*, *thymol*, *pix liquida* or *oleum cadinum*. It is to be remembered, however, that the more chronic the affection and the less the inflammatory symptoms, the more successful is *tar* in the treatment of eczema.

Dr. Duhring considers the following one of the most elegant of the tarry ointments :—

R. Olei cadini, . . . . . f $\frac{3}{2}$  iss  
 Cerati simplicis, . . . . .  $\frac{5}{2}$  j  
 Ol. amygdal. amar., . . . . . gtt. x. M.  
 Ft. ungt.

Or—

R. Picis liquidæ, . . . . . f $\frac{3}{2}$  j  
 Glycerini, . . . . . f $\frac{5}{2}$  j  
 Alcoholis, . . . . . f $\frac{3}{2}$  vj  
 Ol. amygdal. amar., . . . . . gtt. xv. M.

SIG.—To be rubbed firmly into the skin.

The following is Dr. Bulkley's valuable "liquor picis alkalinus":—

R. Picis liquidæ, . . . . . f $\frac{3}{2}$  ij  
 Potassæ causticæ, . . . . .  $\frac{3}{2}$  j  
 Aquæ distillatæ, . . . . . f $\frac{3}{2}$  v. M.

The potassa to be dissolved in water and gradually added to the tar with rubbing in a mortar.

SIG.—To be used diluted.

A very elegant preparation of tar is the French mixture known as "Goudron de Guyot."

For *eczema rubrum*, one of the most intractable varieties of the disease, especially the chronic eczema of the legs, the following mode of treatment, first suggested by Hebra, is the treatment *par excellence*.

The accompanying instructions are to be adhered to. A lump of the *sapo viridis* (made originally of herring fat and potassa, and containing three per cent. of caustic potassa), the size of a small nut, is smeared upon a piece of wet flannel and applied to the affected part, and firmly rubbed until the soap has disappeared, when the flannel is to be dipped into warm water and again applied to the part and rubbed until an abundant lather forms, more water being added from time to time until the suds are most abundant, when the surface is thoroughly washed and freed from all the soap and carefully dried, after which the following (Hebra's diachylon) ointment, having been spread before the application of the soap, is to be applied. It is prepared as follows:—

"Fifteen ounces of the best olive oil are added to two pounds of water, and heated to boiling in the water bath. Three ounces and six drachms of an equally good article of litharge (*plumbi oxidum*) are dusted over the fluid in ebullition, which is constantly stirred

throughout, in order to prevent the formation of fatty acids. During the cooking, water is occasionally added as required. The stirring is to be continued until the ointment is quite cold."

The ointment is spread upon strips of soft muslin and the affected part enveloped, care being exercised that neither folds nor wrinkles occur, the whole being covered by a firm roller and the patient being able to go about as usual. The entire operation is to be repeated twice daily.

A modification of the above ointment, technically known as "*unguentum diachyli albi of Hebra*," has been successful in my hands in a number of marked cases. The formula is :—

R. Emplast. plumbi,  
Vaseline, . . . . . aa . . . . .  $\frac{3}{2}$ j  
Ol. lavendulæ, . . . . . q. s. M.  
Dissolve with heat and stir till cold.

SIG.—Apply on strips, etc.

Prof. Da Costa has used with success in *eczema rubra*, *liquor arsenici et hydrargyri iodidi*, mij-v, t. d., and—

R. Ung. plumbi subacet., . . . . . 3 iv  
Acid. carbolici cryst., . . . . . gr. iij  
Ungt. petroeli, . . . . . 3 iv. M.  
SIG.—Apply freely on muslin strips.

An excellent formula in *eczema vulva* is :—

R. Iodoformi, . . . . . 3 ss  
Bal. peru., . . . . .  $\frac{3}{2}$ j  
Vaseline, . . . . . f $\frac{3}{2}$ j. M.  
SIG.—Apply on soft cloths.

*Eczema capititis* is either erythematous, vesicular or pustular in character. If the first named, it at once tends to become chronic, settling into the variety known as *eczema squamosum*, often involving the entire scalp and accompanied with intense itching. The pustular variety is the more common form, occurring upon the scalp of children and young adults, existing as a few patches, or, what is more frequent, involving the entire scalp. The pustules soon rupture, the liquid drying into greenish-yellow crusts, which, if the affection be extensive, cover the whole scalp with a cap of crust. The hair becomes matted and caked, the sebaceous secretion collects, and if the part be not cleansed the head becomes offensive. In severe cases of

pustular eczema of the scalp, enlargement of the lymphatic glands of the back of the neck and of those behind the ear occur; they never suppurate. Pediculi are frequently associated with eczema capitis of children, either as a primary cause or a result of the matted condition of the hair constituting a favorable habitat for them. When present they call for active treatment.

Eczema capitis may be confounded with psoriasis, seborrhœa, syphilis, tinea favosa, and tinea tonsurans.

*Treatment.* If the *pustular* variety, removal of the crusts is the first indication. This is accomplished by saturating the scalp either with *oleum olivæ* or *oleum amygdalæ dulcis*, and then washing with warm water and soap, or the use of a starch poultice; after their removal the application of the following ointment, used by Prof. Da Costa:—

R. Hydrargyri chlor. mite., . . . . .	gr. xx	
Acid. carbol. cryst., . . . . .	gr. iij	
Ung. petrolei, . . . . .	ʒj.	M.

SIG.—Thoroughly applied.

The late Prof. Ellerslie Wallace was fond of the following:—

R. Sodii carb., . . . . .	gr. xxx	
Ung. petrolei, . . . . .	ʒj.	M.

SIG.—Apply thoroughly after removal of the crusts.

I have usually been successful with cleanliness, proper dietary, the internal use of *liquor arsenici et hydrargyri iododidi*, mss-j, well diluted, after meals, and the local use of *unguentum picis liquidæ* diluted with vaseline.

In cases associated with *pediculi*, I have succeeded with the following, after removal of the crusts:—

R. Hydrargyri ammoniat., . . . . .	gr. x-xx	
Adeps benzoat., . . . . .	ʒj.	M.

SIG.—Thoroughly applied.

For the squamous variety of the scalp, the following formula, recommended by Dr. Duhring, is excellent:—

R. Picis liquidæ, . . . . .	fʒj	
Glycerini, . . . . .	fʒj	
Alcoholis, . . . . .	fʒvj	
Ol. amygdalæ amar., . . . . .	git. xv.	M.

SIG.—Diluted or full strength, rubbed thoroughly into scalp.

*Eczema faciei.* In this location the affection may be either acute or chronic. In adults the erythematous variety is frequently encountered in patches about the forehead and cheeks. Eczema of the face is more common in children, however, the varieties being the vesicular and pustular. It is seen on the forehead, nose and upper lip, and is associated with *severe itching*.

*Treatment.* The same as eczema capitis, or the following:—

R.	Zinc oleat, . . . . .	3j	
	Ung. petrolei, . . . . .	3j.	M.

*Eczema labiorum.* Eczema attacks the lips, either alone or in connection with other parts of the face. One or both lips may be affected. The symptoms are: swelling, redness, heat, infiltration, slight scaliness and fissures. The affection may be in the skin around the border of the mouth, or the vermillion and mucous membrane of the lips. The mouth may be contracted and the lips partly glued together by the exudation and crusts.

Eczema labiorum may be confounded with herpes labialis and syphilis.

*Treatment.* Very difficult and discomforting to the patient. Among the remedies at times successful are: *argenti nitratas, potassa nitratas, acidum carbolicum, pix liquida, oleum ergota* and *collodium flexile*.

*Eczema palpebrarum.* A frequent occurrence in scrofulous children, showing itself along the edges of the eyelids. Pustules involve the hair follicles, followed by the usual crusting. The symptoms are swelling, redness and itching, and unless the parts are frequently cleansed, the lids tend to glue together. Conjunctivitis frequently complicates the affection.

*Treatment.* In mild cases success follows the use of *zinci oleat*, or *glyceritum acidi tannici*. In severe cases the plan recommended by McCall Anderson should be pursued. It consists in the extraction of the eyelashes and touching the edges of the lids with a solution of *potassa* in water, ten grains to the ounce. The edges should be carefully dried and the lid everted, a very small quantity on a delicate brush being applied, immediately neutralizing the alkali with *acidum aceticum* or vinegar.

*Eczema barbæ.* Eczema of the beard is characterized by the formation of extensive pustules, with preference for about the hairs, drying as yellowish or greenish crusts, matting the hairs together and adher-

ing to the parts. The affection may be confined to the hairy portions of the face, or extend to other regions of the face, be localized or general, acute or chronic.

Eczema barbæ in general features somewhat resembles both tinea sycosis and sycosis non-parasitica, but sycosis is an inflammation of the hair follicles only and is rarely associated with crusting, while crusting is abundant in eczema.

*Treatment.* Must be energetic and decided. The crusts are to be removed by poultice or warm water and soap. Then the part is to be cautiously shaved; although quite painful the first time, it is hardly so afterward, as it is to be repeated every two or three days. After shaving, if the attack be acute, the same plan of medication as recommended by Hebra for eczema rubrum is to be practiced, the application to be continuous both day and night, or only at night. If the attack be chronic, the following ointment should be applied after cleansing and shaving the beard:—

R.	Hydrargyri ammoniat,	gr. xv-xxx
	Sulphur,	3 ss-j
	Ung. petroeli,	3 j.
Sic.—	To be thoroughly applied.	M.

In this variety of eczema I have seen marked benefit from the use of *liquor arsenici et hydrargyri iodidi*, mij-v, three or four times daily.

*Eczema aurium.* Eczema of the ears may be either erythematous, vesicular or pustular. If the former, thickening results, with desquamation of flakes or large scales; if either of the latter, crusts form, which may envelop the whole ear, the symptoms being swelling, redness and severe burning and itching, and if the process extend into the meatus, occlusion may result, causing temporary deafness. The most characteristic symptoms of erythematous eczema of the external auditory canal, besides the appearance of small flakes, is intense and persistent itching.

*Treatment.* For acute vesicular or pustular eczema, removal of the crusts and the use of *hydrargyri chloridi mite* as an ointment of the strength of thirty grains to the ounce. If chronic, the use of *pix liquida*, as already suggested. For chronic erythematous eczema of the external auditory canal, the following formula has generally controlled this stubborn condition:—

R.	Hydrargyri flav. oxid., . . . . .	gr. j-ijj	
	Morphinæ sulph., . . . . .	gr. j	
	Vaseline, . . . . .	3 ij.	M.

SIG.—Apply to the canal.

*Eczema genitalium.* This is a most distressing condition. In the male the scrotum and penis are involved alone or together, the former alone being the more common, and is complicated with eczema of the inner side of the thigh or thighs. The symptoms of eczema of the scrotum are, swelling, often œdema as well, moisture, crusts, and painful fissures, followed by extensive thickening and accompanied by intense itching. In the female the affection attacks the labia, and, rarely, the vagina and mons veneris, and may extend to the surrounding parts, especially to the perineum. The symptoms of eczema of the labia are, great swelling, œdema, redness, with great heat and a free discharge, forming crusts, which are apt to glue the opposing surfaces together. If the variety be the erythematous, in place of a discharge with crusts, the symptoms named are followed by slight scales. The itching is most violent and distressing.

*Treatment.* The parts attacked should be kept constantly enveloped in cloths wet with a saturated solution of *acidum boracicum* until the more pronounced inflammatory symptoms subside, when should be applied ointments of *zinci oleat.* or *hydrargyri chloridum mite.* Persistent cases will often succumb to the plan of treatment suggested by Hebra for *eczema rubrum*.

*Eczema ani.* The anus may be attacked alone or associated with eczema of the perineum and genitalia. The symptoms are: redness, swelling, infiltration, and thickening, with or without fluid exudation. Fissures of the anus are usually present, and add to the distress of the patient, the pain attending each stool. Persistent itching and burning, worse after retiring, adds to the misery of the patient.

*Pruritus ani* may be mistaken for *eczema ani.* In the former the itching is only associated with such symptoms of inflammation as result from the irritation of scratching, while in the latter inflammatory symptoms precede the itching.

*Treatment.* The more acute symptoms are relieved by bathing the parts with a solution of *acidum boracicum*, after which a weak application of *acidum carbolicum*, either as a lotion or ointment. The late Prof. S. D. Gross recommended the application of the following:—

R.	Zinci oxidi,	3vj	
	Hydrargyri chlor. corrosiv.,	gr. j	
	Glycerini,	3ij.	

M.

SIG.—Apply thoroughly to affected parts.

*Eczema intertrigo.* Parts of the body that naturally come into contact with each other, as about the joints, the inner surfaces of the nates, in the groins and beneath the mammae, are frequently attacked with erythematous eczema, which is frequently, but erroneously, termed erythema intertigo or chafing. The symptoms are: redness, heat, and a moist, macerated surface, aggravated by movement of the affected parts.

*Treatment.* The application of a solution of *acidum boracicum*, or the use of dusting powders, such as *zinci oleat.*, *amylum* or *hydrargyri chloridum mite*. It is essential for successful treatment that the opposing surfaces be separated by means of lint or cloths.

*Eczema mammarum.* The nipples, and more particularly those of primiparæ, are at times the seat of a vesicular eczema, with the formation of crusts and fissures, and unless speedily relieved develops eczema rubrum. The pain on nursing becomes so severe that the mother is compelled to refuse the child. It must be borne in mind that eczema mammarum occurs in women who are not nursing and in single women.

*Treatment.* Dr. Tilbury Fox advises the following plan:—

"1. Great cleanliness and care in washing away any remnants of milk after each time that the child is put to the breast; and, if the nipple be tender and excoriated, use—

"2. A little liquor plumbi and calamine powder, as follows:—

R.	Liq. plumbi,	f3iss	
	Pulv. calaminæ prep.,	3iss	
	Glycerini,	3j	
	Adipis, ad	3j.	M.

"3. I cover over the nipple with a lead nipple shield. This excludes the air, keeps the part from being chafed, and I think the lead does good after the part has become less red and sore. I often use a little glyceral tannin, painted on night and morning.

"The above application can always be removed with a little cold cream and a little warm water sponging before the child goes to the breast."

*Eczema palmarum et plantarum.* The features of the affection in both these regions are identical. The diagnosis is often obscured by the thickened state of the epidermis. The symptoms are : infiltration, thickening, callosity, moisture followed by dryness, and fissuring, the last named frequently becoming so deep and painful that the patient is unable to use his hands, or, if on the soles, to walk.

The affection is mostly chronic, affecting either of the parts alone, or all at one and the same time. Itching is a constant and annoying symptom.

The diagnosis is to be made between eczema of these parts and psoriasis or syphilis.

*Treatment.* The plan of Hebra for eczema rubrum will usually be successful for this variety. The following formula is also valuable :—

R.	Hydrargyri oleat.	5-15 per cent., . . . . .	ʒ iv	
	Olei cadini,	. . . . .	ʒ ss	
	Cerat. simp.,	. . . . .	ʒ iv	M.

SIG.—Rub well into part morning and night, first macerating with hot water.

*Eczema unguium.* The nails are seldom attacked alone, but in connection with eczema manuum. The symptoms are roughness, want of polish, unevenness and a punctate or honeycomb appearance similar to that seen in psoriasis of the nails. The nail becomes depressed, particularly at its root, thus interfering with its nutrition, resulting in loss of this appendage.

*Treatment.* Internally *arsenicum* is of the greatest value. Locally, the following :—

R.	Ung. picis liq.,	. . . . .	ʒ iv	
	Hydrargyri chlor. mite	. . . . .	ʒ ss	
	Vaselini,	. . . . .	ʒ iv	M.

SIG.—Apply thoroughly.

It is a remarkable clinical fact, that very many cases of eczema, whether acute, subacute or chronic, are rapidly cured by the use of *potassii iodidum* in variable doses.

## URTICARIA.

**Synonyms.** Hives ; nettle-rash.

**Definition.** An inflammation of the skin characterized by the development of wheals of a whitish, pinkish or reddish color, accompanied by stinging, pricking and tingling sensations.

**Causes.** Very frequently the result of sudden surface hyperæmia, or rather too rapid circulation through the superficial capillaries, the result of exposure to heat. Irritants and poison produce an attack when brought in contact with the skin. Gastric, intestinal, hepatic, nephritic, ovarian, uterine and cystic derangements are very frequent causes. Certain medicaments; malaria; nervous disorders; associated with purpura and rheumatism; pregnancy; lactation; menopause.

**Pathology.** An acute inflammation of the papillary layer of the skin; characterized by the rapid development of a "wheal"—a more or less firm elevation—consisting of a circumscribed collection of a semi-fluid material, the result of a rapid exudation into the upper layers of the skin. The production of the wheal is the immediate result of a disturbance of the vaso-motor system, which is shown by the interference of the circulation in the wheal, the blood being driven from its centre to its periphery, causing the whitish apex and red areola, so characteristic of the developed wheal.

**Symptoms.** An attack of "hives" is characterized by the sudden development of *wheals* upon the cutaneous surface, which usually as suddenly disappear, their site being temporarily marked by a spot of redness or hyperæmia.

With the appearance of the wheal occur distressing *itching, burning, tingling, crawling, pricking and stinging sensations*, to relieve which the patient still further irritates, tears or otherwise wounds the surface by scratching, whence are often developed deep-colored, flat, lenticular papules.

Very frequently an attack of "hives" is associated with fever, headache and gastric disorder. The "wheals" may appear upon any portion of the body; their size varies from that of a pea to that of a walnut or an egg—the "giant wheals;" the number varying from a very few to being so numerous as to cover the whole surface of the body. The shape, size, color and number of the wheals that may occur in any given case have given rise to a number of names to designate the lesions. Thus, *urticaria annularis* occurs in rings; *urticaria figurata* occurs in spirals; *urticaria vesiculosus* has a vesicular development on the summit of the wheal; *urticaria bullosa*, a bullous development at the summit; *urticaria papulosa* or *lichen urticatus*, the wheal and a small papule are combined; *urticaria tuberosa*, or

giant wheals; *urticaria hemorrhagica* or *purpurata urticaria*, a combination of urticaria and purpura; *urticaria evanida*, a rapid appearance and disappearance of the lesion; *urticaria persistans*, slow disappearance; *urticaria conferta*, when the wheals are confluent; *urticaria pigmentosa*, where the wheals are succeeded by pigmentations of the site, the tints varying from dark brown, greenish yellow, to a chocolate color; *urticaria febrilis*, when the wheals are associated with fever; *urticaria ab ingestis*, when associated with indigestion.

**Treatment.** To prevent the recurrence of the disorder a thorough investigation of the cause must be made, and when found (not always possible) be removed.

Attention should be directed to the state of the general health, the diet and the secretions.

The following remedies, alone or variously combined, are often of benefit: *quinina*, *sodii salicylas*, *pilocarpus*, *atropina*, *tinctura belladonnae*, *ammonii chloridum*, *arsenicum* and *potassii bromidum*. The following pill is valuable in many cases:—

If there be atonic dyspepsia and constipation, the following combination is useful:—

R.	Magnesii sulphat., . . . . .	ʒj
	Ferri sulphat., . . . . .	gr. xvj
	Sodii chloridi, . . . . .	ʒ ss
	Acidi sulphurici dil., . . . . .	fʒij
	Inf. cascarillæ, . . . . ad . . . .	fʒ iv.
		M.

SIG.—Tablespoonful before breakfast, diluted.

*Local* measures are of the greatest value, either as baths, lotions or dusting powders. The following are among the most serviceable: sponging with *alcohol, brandy, whisky, vinegar and water, salt water, alkaline baths* and *acid baths*. Duhring recommends the following:—

R.	Acidi carbolici, . . . . .	3 iss
	Glycerini, . . . . .	f 3 ij
	Alcoholis, . . . . .	f 3 viij
	Aq. amygdal. amar., . . . . .	f 3 viij.

SIG.—Use as lotion, two or three times daily.

Bulkley suggests the following:—

A serviceable formula is the following:—

R. Chloroformi, . . . . . f  $\frac{3}{2}$  ij.  
Ung. zinci oxid., . . . . .  $\frac{3}{2}$  ij. M.  
SIG.—Apply with hand.

HERPES.

**Definition.** An acute inflammation of the skin; characterized by the development of one or more groups of *vesicles*, filled with a clear serum, occurring for the most part about the face (*herpes facialis*), and genitalia (*herpes progenitalis*).

**Causes.**—*Herpes facialis*: during the course of febrile and nervous disorders; in connection with digestive disorders and colds.

*Herpes progenitalis*; the origin is local, from uncleanliness or friction.

**Pathology.** Hebra defines the various forms of herpes as "a series of acute cutaneous diseases of cyclical course, marked by an exudation which collects in drops under the epidermis and elevates it; forming vesicles which are never solitary, but always appear in groups."

**Symptoms.** The appearance of the vesicles is usually preceded by a feeling of heat in the region, together with slight tumefaction or swelling. Rarely the herpetic attack is attended with malaise and pyrexia.

The eruption usually appears in the form of a small cluster of pin-head to split-pea-sized vesicles, containing a clear fluid, becoming cloudy, afterward puriform and dries in small, yellowish or brownish crusts; they are few in number and may coalesce. They disappear without leaving a scar.

*Herpes facialis*; occur upon any portion of the face, but most frequently about the lips—*herpes labialis*. The alæ of the nose, auricles and the mucous membranes of the mouth and tongue are

frequent locations, in the latter appearing as excoriated patches from rupture of the vesicles.

*Herpes progenitalis*; in the male the chief site is the prepuce (*herpes præputialis*). In the female they are comparatively rare; but when occurring it is upon the labia majora and minora and the skin about the vulva.

This variety is preceded by burning, itching or neuralgic pains, accompanied with redness, congestion and more or less œdema.

The lesion in these parts is likely to be mistaken for one form or other of venereal disease.

*Herpes gestationis*; a rare affection of the skin occurring during pregnancy, consisting of erythema, papules, vesicles and bullæ, attended with intense burning and itching. It may appear at any time of pregnancy up to the seventh month, and continues until some time after delivery.

**Treatment.**—*Herpes facialis* seldom calls for treatment, although in marked cases of *herpes labialis* protection with *liquor gutta-perchæ* or *collodium flexile* promote desiccation.

*Herpes progenitalis*; cleanliness is of the first importance. Coating the eruption with the medicaments mentioned above or washing with a saturated solution of *acidum boracicum*, and afterward dusting with *hydrargyri chloridum mite*, are useful.

The parts may be rendered less sensitive in frequently recurring cases by astringent lotions, as *acidum tannicum* or *zinci sulphas*. Circumcision, where required, may be practiced.

## HERPES ZOSTER.

**Synonyms.** Zona; shingles; a girdle; intercostal neuralgia.

**Definition.** An acute, inflammatory disease; characterized by the development of groups of firm and distended vesicles situated upon inflamed bases corresponding to a definite nerve trunk, and accompanied by more or less severe neuralgic pains.

**Causes.** The eruption and consequent neuralgic pains are the immediate result of an inflammation of the ganglia or of the nerve trunks and branches—a *neuritis*—probably of the trophic fibres of the affected part; but the cause producing this condition is obscure. Among the many that have been suggested are: cold, injuries to nerves, anaemia, and the medicinal use of arsenic.

**Pathology.** An inflammation of either the ganglia, the nerve trunk or branches—probably the trophic system—causing the development of vesicles in the lower strata of the rete, with “the infiltration of serum and inflammatory cells” of the papillæ and corium.

**Symptoms.** Begins with *neuralgic pains*, either of a burning or lightning-like character, with slight febrile phenomena, followed by the appearance of *papulo-vesicles along the tract of pain*; these soon become *vesicles* situated on bright red, highly-inflamed bases. The vesicles are about the size of pin heads, or perhaps a little larger, usually discrete, although they frequently coalesce, forming irregular patches, coming in groups until the third to the fifth or even tenth day, when they gradually desiccate, and at the end of the second week nothing remains but a slight scar, which may also disappear after a time or, rarely, is permanent.

When the eruption is at its height it is perfect in its anatomical formation, each vesicle being well-shaped and seated on a bright red, inflamed patch of skin, and distended with a translucent, yellowish fluid.

The eruption is almost invariably confined to one side (unilateral) of the body, although, in rare instances, it is seen upon both (bilateral) sides. It is usually found upon well-known nerve tracts. According to the region affected it is termed *zoster capitis*, *zoster frontalis*, *zoster faciei*, *zoster ophthalmicus*, *zoster auricularis*, *zoster nuchæ*, *zoster brachialis*, *zoster pectoralis*, *zoster abdominalis*, *zoster femoralis*.

In the very young the eruption may develop and pursue its course without the neuralgic pains.

**Diagnosis.** The characteristics of herpes zoster or shingles are usually so well marked that an error in diagnosis should not occur. The neuralgic pain preceding the eruption and its development in distinct groups upon inflamed bases following a nerve tract are so different from simple herpes of the face, or genitalia, or from the lesion of eczema.

**Prognosis.** Favorable. The affection is self-limited, the duration being about two weeks. It is said that “zoster of the orbital region may seriously involve the eye and prove fatal.”

**Treatment.** The affection being self-limited, it follows that remedies to cut it short are useless. The following combination diminishes the pain and modifies the duration :—

R. Zinci phosphidi,

Ex. nucis vom., . . . . . ää . . . . . gr. x.

M. et. ft. pil. No. xxx.

SIG.—One every two to four hours. (BULKLEY).

Prof. Bartholow "has seen excellent results in cases of shingles from galvanization of the affected intercostal nerves—the positive pole being placed over the point of emergence of the nerves, and the negative brushed over the terminal filaments in the skin."

The general symptoms are to be treated as indicated. Anæmia or depression are benefited by full doses *ferri et quininæ citras*.

For the pain no remedy seems comparable with the hypodermic use of *morphinæ sulph.*, gr.  $\frac{3}{8}$ - $\frac{1}{2}$  with *atropinæ sulph.*, gr.  $\frac{1}{100}$ , near the lesion. *Antipyrine*, gr. xv, repeated every three or four hours, relieves the pain in many cases.

*Locally*, relief follows coating the "shingles" with either *collodium flexible* or *liquor gutta-percha*, to which *morphinæ sulphas* may be added.

### MILIARIA.

**Synonyms.** Lichen tropicus; miliaria rubra; miliaria alba; prickly heat.

**Definition.** An acute inflammation of the sweat glands; characterized by the development of discrete, whitish or reddish, pin-point and millet-seed-sized papules, vesicles or vesiculo-papules, productive of pricking, tingling and burning sensations of a most aggravated character.

**Causes.** Excessive heat, the result of excessive or tightly-fitting clothing, or a high external temperature. Most common in fleshy adults who perspire freely, and in children. Nervous prostration; severe dyspepsia and general debility seem to predispose to "prickly heat."

**Varieties.** *Miliaria papulosa*; *miliaria vesiculosus*.

**Pathology.** The pathology of the two varieties is the same, both being inflammatory affections of the sweat glands; in the one papules, and in the other vesicles develop about the orifices of the excretory ducts.

In either variety there occurs hyperæmia of the vascular plexus of the sweat gland, followed by slight exudation about the ducts, giving rise to the minute papule or vesicle, which remain until the cause has been modified or removed, when they are rapidly absorbed.

**Symptoms.** *Miliaria papulosa*; known as lichen tropicus and "prickly heat," is of sudden onset, with the occurrence of numerous minute, acuminated *bright red papules*, about the size of a pin head or millet-seed, and but slightly raised above the level of the skin. The papules are preceded by and accompanied with *sweating* (hyperidrosis), and *distressing tingling, pricking and burning sensations*. If the attack be severe, *vesico-papules* and *vesicles* are freely interspersed among the numerous papules.

*Miliaria vesiculosa*; in this variety, instead of papules, immense numbers of *vesicles* develop, of the size of pin points and pin heads, of a whitish (*miliaria alba*) or yellowish-white color. The surface from which they arise is of a bright-red color, owing to each vesicle being surrounded by an *areola* (*miliaria rubra*). The vesicles are preceded and accompanied with *sweating* (hyperidrosis) and most distressing, *tingling, pricking and burning sensations*.

Either variety may attack all parts of the body, but the abdomen, chest, back, neck and arms are the regions usually invaded.

**Duration.** This varies with the cause. It may appear, fully develop and disappear in a few hours. In those predisposed, it may continue more or less marked throughout the entire summer.

**Diagnosis.** If the cause, nature and seat of the affection are taken into consideration, no error should occur.

Eczema papulosum has a resemblance to "prickly heat," but the course of eczema is slow, and the papules are larger, more elevated, and firmer than those of *miliaria papulosa*.

Eczema vesiculosum and *miliaria vesiculosa* are to be differentiated by the marked differences in the progress of each, the former slow, the latter rapid, the vesicles of the former rupturing spontaneously, those of the latter only when severely irritated.

Sudamen is not an inflammatory affection, while *miliaria* is.

**Prognosis.** The affection is often most rebellious in fleshy persons and children, and if neglected it passes into eczema or an erythematous intertrigo.

**Treatment.** The patient should be kept as cool as possible, and avoid undue perspiration. The fears entertained by the laity, of danger from retrocession of the eruption, are groundless; the sooner it disappears the better for the comfort of the patient.

The food should be light and unstimulating; wine, spirits and beer are to be avoided.

The ingestion of water, lemonade, Apollinaris water, Vichy water, together with refrigerant diuretics, as *potassii citras vel acetum*, a cool apartment, and absolute rest will ordinarily insure speedy relief.

*Locally*; sponging with alkaline lotions, *liquor plumbi subacetatis dilutus*, *extractum grindeliae fluidum* well diluted, or *cupri sulphuris*, in solution (gr. x, aquæ, f  $\frac{3}{5}$ j), or *acidi carbolici*, gr. xx, *glyceriti amyli*,  $\frac{3}{5}$ ij, or a dusting powder, consisting of *lycopodium*, *zinci oxidum* and *amylum*, singly or combined.

## PEMPHIGUS.

**Synonym.** Water blisters.

**Definition.** An inflammatory disease of the skin, either acute or chronic, characterized by the development of a succession of rounded, irregular-shaped blebs or bullæ, varying in size from a pea to an egg.

**Varieties.** *Pemphigus vulgaris*; *pemphigus foliaceus*.

**Cause.** Obscure. It is usually associated with a depressed state of the general system; disorders of menstruation; during pregnancy.

**Pathology.** Hebra thus describes the appearance of the blebs: "Sometimes a circumscribed, light-red spot appears, perhaps of the size of a bean or large coin; this is paler in the centre, and may even present a tinge of white, indicating the point at which the bleb is to form, and from which it will spread outward over the surrounding skin, and, in fact, is at first a wheal, passing afterward into a bleb. In other cases the bleb is not preceded either by a red spot or by a wheal, but begins originally as a small collection of clear fluid beneath the cuticle. Thus, hyperæmia of the skin may exist before exudation is poured out, or the latter may be formed before any congestion of the papillary layer is discoverable."

The contents of the blebs or bullæ are yellowish or colorless serum, of a neutral or alkaline reaction, the older the fluid the more alkaline it becomes. In the late stages of a bleb the fluid becomes puriform. In rare instances blood is contained in the bleb (*pemphigus hemorrhagicus*).

**Symptoms.** *Pemphigus vulgaris*; the onset is slow (*pemphigus chronicus*), without constitutional symptoms, or acute (*pemphigus acutus*) preceded by febrile reaction. The lesions are the successive development of *blebs*, usually from half a dozen to a dozen, varying in size from a pea to an egg, of a round or oval shape, their walls dis-

tended with a colorless fluid, the color becoming yellowish or puriform as they grow older. They develop abruptly from the sound skin, with a definite line of demarcation, unattended with symptoms of inflammation. A characteristic phenomena of the lesion is their successive appearance; a crop no sooner disappears than another forms, throughout the course of the affection, each crop running its course in from three to six or ten days. With the appearance of the blebs occur *itching* and *burning*, usually of a mild character, although occasionally in a distressing degree (*pemphigus pruriginosus*).

*Pemphigus malignus* is characterized by the great size and number of the blebs, which coalesce, rupture and are succeeded by excoriated surfaces which occasionally take on ulcerative action, the patient's health being seriously impaired.

*Pemphigus foliaceus* differs from *pemphigus vulgaris* in that the blebs, instead of being distended or tense, are flaccid and only partially filled with fluid, as they rupture before arriving at their state of full development. This variety also appears and disappears in crops. After rupture the fluid immediately dries into thin whitish flakes, which are detached in quantity, leaving a red, excoriated surface—the rete and corium. If the affection has continued for some time, the skin presents the appearance of a superficial scald. The course of this variety is essentially chronic.

All portions of the body are liable to the lesion, as also the mucous membrane of the mouth and vagina. It is most common, however, upon the limbs.

**Diagnosis.** In a typical case no difficulty should be experienced in making a diagnosis. The mere presence of blebs, however, does not necessarily constitute *pemphigus*, for it must be remembered that they are at times developed in other diseases as well as by artificial means; the appearance of blebs in crops is a strong diagnostic point.

**Prognosis.** The course of the affection is most uncertain, and relapses are frequent. In arriving at an opinion, the occurrence of fatal cases must not be forgotten.

**Treatment.** Attention to the general health of the patient is of the greatest moment. A careful study of the cause should be made, and if determined, means for its removal are of the first importance.

Two remedies, *arsenicum* and *quinina*, are of great value, the secret of success being the persistent use of the former; or if the latter be used, the dose should be large.

*Local* measures are also of importance. The blebs should be punctured and evacuated as soon as formed. The use of dusting powders of *zinci oxidum*, *amyrum*, or *violet-powder*, or lotions of *liquor plumbi subacetatis dilutum*, are valuable.

Hebra recommended the continuous bath.

### IMPETIGO.

**Definition.** An acute inflammatory disease, characterized by the development of one or more discrete, rounded and elevated firm *pustules*, about the size of a pea, unattended with itching.

**Causes.** Occurs for the most part between the ages of three and ten years, in the well nourished and healthy. It is not associated with *eczema*. It is not contagious.

**Pathology.** The lesion is a well-formed, typical *pustule*, developing abruptly from the surface, containing a whitish-yellow fluid, pus corpuscles, blood corpuscles, epithelial cells and cellular detritis. The abscess or pustule is about the size of a pea, circumscribed and superficial.

**Symptoms.** The affection manifests itself by the development of from one or two to a dozen or more distinct *pustules*, about the size of a split pea, of a rounded shape, raised above the surface, with thick walls, of a yellowish or whitish color, surrounded by a distinct areola, which soon fades, are without a central depression or umbilication, and unattended with either itching or burning.

The affection runs an acute course, usually lasting a couple of weeks. The pustules, after attaining their full size, remain stationary for a few days, when they disappear by absorption and desiccation, the crusts dropping off, displaying a reddish base, which soon disappears with pigmentation or scar.

The pustules occur on all portions of the body, the most frequent locations being the face, hands, fingers, feet, toes and lower extremities.

**Diagnosis.** Impetigo is unassociated with general symptoms, and its particular lesion—the pustule—is discrete, points of importance in the diagnosis.

Eczema pustulosum is also a pustular affection, but the large number, their disposition to coalesce, their location upon an inflammatory base, their rupture and subsequent crusting and itching, are diagnostic points.

The diagnostic points from ecthyma will be pointed out when describing that affection.

**Prognosis.** Favorable.

**Treatment.** The pustules should be opened as soon as they mature, the contents removed by washing with tepid water and soap, and the floor covered with *hydrargyri chloridum mite* or *zinci oleat*.

Coating the pustules with *collodium flexible* or *liquor gutta-percha*, if they are located where irritation be liable, is a valuable mode of treatment.

## ECTHYMA.

**Definition.** An affection of the skin, characterized by the formation of one or more large, isolated, flat *pustules*, situated upon an inflammatory base.

**Cause.** It is most common among those who live in squalor and poverty, and in delicate and poorly-nourished children. Improper and insufficient diet, want of ventilation, excessive work, and uncleanliness are all prominent causes.

**Pathology.** The lesion is a typical pustular process, severe but superficial, and not extending beyond the papillary layer of the corium. The pustule is situated upon a firm and highly-inflamed base; the number varies from one to a dozen or more.

**Symptoms.** The disease is characterized by the development of one or more round or oval, yet *flat*, *pustules*, about the size of a pea-bean, attended with a moderate *heat*, *burning* and *pain*, and if the number be large, slight febrile reaction. The pustules are first *yellowish in color*, surrounded by a firm and sensitive *bright-red areola*, the pustule afterward becoming reddish from the admixture of blood, soon drying into flat crusts of a brownish color. The duration of each pustule is between two and three weeks, new ones forming, until the cause is removed.

The most prominent sites are the thighs, legs, shoulders, and back.

**Diagnosis.** Ecthyma and eczema pustulosum have points of resemblance, but a study of the clinical history of the latter should prevent error.

Impetigo differs from ecthyma in the size of the pustule and crust.

Ecthyma differs from a boil in not having a central core.

**Prognosis.** With care and the removal of the cause, recovery is always prompt.

**Treatment.** The general treatment of the patient is of the first importance. Nutritious and wholesome food, cleanliness, bathing, fresh air and regulated exercise should be advised, together with such tonics as *ferrum*, *arsenicum*, *quinina*, *strychnina* and *mineral acids*.

*Locally* : remove the crusts by first soaking with oil or fat, or water dressings, and apply—

R. Ungt zinci oxid. benz., . . . . .	ʒss
Vaselini, . . . . .	ʒss
Hydrargyri ammoniati, . . . . .	ʒj.
Ft. ungt.	—DUHRING.

Pustules showing a sluggish disposition to heal should be stimulated by touching with either *argenti nitras* or *acidum carbolicum*.

## FURUNCULUS.

**Synonyms.** Furunculosis ; furuncle ; boil

**Definition.** An acute affection of the skin, characterized by the occurrence of one or more circumscribed cutaneous or subcutaneous abscesses (boils), which usually terminate by necrosis of the central tissue, its subsequent expulsion in the form of pus or a core, and a resulting cicatrix.

**Cause.** The result of a depraved condition of the system, induced by general debility, excessive fatigue, nervous depression, improper food and exercise, anaemia, diabetes, uræmia, or the result of local friction, pressure or contusions.

**Pathology.** The process resulting in a "boil" has its origin in either a sebaceous gland, a sweat gland, or a piliary follicle, and never begins in the meshes of the corium. "It begins as a small, roundish spot, which increases in size until certain dimensions are attained, when it undergoes suppurative change, resulting in the formation of a central point or core, composed of the tissue of the gland in which the furuncle originated, which, together with the pus is cast off. It shows no disposition to become diffuse, being always a circumscribed inflammation. After the discharge of the core, a cavity of more or less depth remains, showing the tissues around it to be hard and infiltrated. After a few days or a week it fills up by granulation, leaving a cicatrix,

which is often permanent. The central point or core, when thrown off, is composed of a whitish, tough, pulaceous mass of dead tissue, varying in size with the extent and depth of the inflammation." (Duhring.)

*Hydro-adenitis*, as seen in the axillæ, around the nipples and about the anus or perineum, differs from the ordinary "boil" merely in being deeper seated.

**Symptoms.** "Boils" may occur singly, or more commonly in crops of two, three or more, another crop following their disappearance (*furunculosis*.)

The abscess begins as a small, rounded, imperfectly defined, isolated, reddish spot, of a highly inflamed character, painful on pressure, its size gradually increasing, its central point presenting evidences of suppuration. It reaches its full development in about a week, when it consists of a slightly raised, rounded and pointed inflammatory swelling with a yellowish point in the centre—the "core." Abscesses with no central suppuration or core are called "blind boils." The size of a developed boil varies from a split pea to a walnut, the color deep red, with a yellow centre, and is surrounded by a slight areola. The pain of a boil is dull and throbbing, painful on pressure, and is usually worse at night. The constitutional symptoms are mild or severe, according to the number and size of the lesions.

Any portion of the body may be attacked; its preference, however, is for the face, neck, back, axillæ, nipples, buttocks, anus, perineum and labiæ.

**Diagnosis.** The characteristics of furuncle are so marked that an error seems impossible. It may be, however, mistaken for carbuncle, the differences between which will be pointed out when discussing that affection.

**Prognosis.** No danger results from occasional boils, but when occurring in crops they impair the general health and are rebellious to treatment.

**Treatment.** The treatment of a single boil is well expressed in the word "time;" warm applications are said to hasten the stage of suppuration, and when reached an incision permits the expulsion of the "core," after which the cure soon follows. If the lesion is located where friction or pressure is likely, protection by either covering with adhesive or soap-plaster, smoothly spread, is ample.

When, however, successive crops of boils occur (*furunculosis*), the

treatment should be both constitutional and local. The economy being below par, such tonics as *arsenicum*, *quinina* and *ferrum* are of value. *Calcii sulphid.*, gr.  $\frac{1}{2}$ - $\frac{1}{8}$ , every two or three hours, is valuable in these cases.

Locally, attempts to abort the process may well claim attention, among which are : crucial incisions, to relieve the tension of the central point, will often abate the inflammation and prevent the gangrene ; this little operation is rendered painless by the use of the ether spray. *Acidum carbolicum*, used in five per cent. solution, of which two to five drops injected into the apex of the boil, is valuable. Painting the forming boil with *argenti nitras* or *tinctura iodi*, are also recommended ; a paste made by adding together equal parts of *glycerinum* and *extractum belladonnæ* will often abort a boil ; the same is also claimed for *unguentum hydrargyri nitratis*.

## ANTHRAX.

**Synonyms.** Carbunculus ; carbuncle.

**Definition.** An indurated, more or less circumscribed, dark red, painful, deep-seated inflammation of the skin and subcutaneous connective tissue, terminating in a slough and the subsequent production of a permanent cicatrix.

**Causes.** Not positively determined. A deep-seated bruise is a supposed cause. Perhaps, as in furuncle, impairment of the general health is the important factor. It is generally noted to occur in middle life and old age, and in men more frequently than in women. A "specific" cause for anthrax is not an improbable discovery.

**Pathology.** Although Billroth regards furuncle and carbuncle as differing only in degree, the explanation of Warren, of Boston, seems the more probable, he being the first to call the attention of histologists "to the existence of small columns of adipose tissue leading from the panniculus adiposus up to the roots of the lanugo hairs, taking an oblique direction in a line with the *erectores pilorum*. The inflammation resulting in suppuration of the subcutaneous adipose tissue, must either form an abscess or become diffuse. In phlegmonous erysipelas the latter condition is observed. But when the inflammation is in the dermoid texture, the exudates infiltrate the skin and naturally follow the canals occupied by the 'columnæ adiposæ.' The pressure thus exerted upon the whole dermoid tissue cannot fail to

strangulate the circulation, and thus produce gangrene of the tissue, even if the exudate be not poisonous enough to destroy the cell by its presence. It can, by this explanation, be easily understood why this disease is apt to affect the skin on the nape of the neck and the back more than on other parts of the body. At this point the skin is dense, its fibrous element extending deep into the adipose layer, which is surrounded with strong bands; hence, the pus confined in such a place, seeking the easiest outlet, will travel along these miniature adipose canals, producing the peculiar appearance pathognomonic of carbuncle."

**Symptoms.** Carbuncle is recognized by its peculiar form; commencing in the lower layers of the cutaneous tissue, it first resembles somewhat a phlegmon *minus* its bright redness. At first it is somewhat rounded, with a strong tendency to the production of *vesicles* on its surface, soon, however, becoming firm, circular and flat, and raised above the surrounding parts, spreading through the subcutaneous tissue and skin, becoming at times enormously large, and having a dark red or violaceous color. As the disease progresses, the pressure results in the softening of the tissues, the skin becoming gangrenous, breaking down at numerous points, forming perforations, through which centres of suppuration appear in different stages of advancement, either as whitish, fibrous plugs, or as cavities, from which a yellowish, sanguous fluid oozes, the surface of the anthrax having a cribriform appearance, perforated like a sieve. The entire mass terminates in a slough, which, on being detached, leaves a large, open, deep ulcer, with firm, everted edges, granulating slowly, a permanent cicatrix marking the site of the lesion. The development of the carbuncle is attended with *severe pain of a deep throbbing and burning character.*

The *constitutional symptoms* vary with the size, number and severity of the disease; loss of appetite, coated tongue, general malaise, and moderate febrile reaction accompanies all cases, to which are added those of *septicæmia* in severe cases.

The duration is from two to six weeks. Its favorite site is the back of the neck, shoulders, back and buttocks. It is usually single.

**Diagnosis.** The disease is distinguished from furuncle by its great size, *its flat form*, its course, the multiple points of suppuration, and the character of the slough. Also by the pain; in furuncle, sensitive and painful to the touch, carbuncle not being particularly

sensitive. Furuncles generally occur in numbers or in crops; carbuncle is almost always single.

**Prognosis.** A guarded opinion should always be given, as death is not infrequent from anthrax, especially in elderly people with impaired health. The mortality, however, is not so great as the laity suppose.

A great danger is septicæmia, from the action of the poison on the blood, or the result of secondary abscesses.

**Treatment.** Constitutional and local measures are both of the greatest value. Nutritious diet, stimulants and full doses of such remedies as *tinctura ferri chloridi*, *quininæ sulphas*, *arsenicum* and *ammonii carbonas* are beneficial. Good results are reported from *calcii sulphid.*, gr.  $\frac{1}{8}$  every two hours.

*Locally*; the crucial incision, so generally practiced in former years, is seldom performed now, the frequent occurrence of hemorrhages being too debilitating. The following are valuable plans:—

*Caustic potash*, applied to the carbuncle before an opening occurs, until an eschar is fully formed; or, making several small punctures with a scalpel and inserting a small piece of caustic potash well into the diseased tissue; or, if openings have already occurred, insertion of the caustic stick into them, allowing it to remain until melted. By either of these methods I have seen the slough cast off more readily than in cases where the crucial incision was made or in those left to nature. Another method is, "a saturated solution of pure *acidum carbolicum* is injected through the several apertures in every direction into the sloughing tissues, by the aid of an hypodermic syringe. The pain is severe but short-lived."

Prof. Agnew recommends painting *collodium cum cantharide* around the anthrax, in the form of a broad zone, the effect of the blister being to relieve the tension. *Tinctura iodi*. is also used for a similar purpose. Hebra advocates cloths wrung out in ice water, or ice bags, in the early stage, changing to warm fomentations as soon as suppuration has begun. Dr. Ashurst has practiced with success the use of pressure by means of adhesive plaster applied in much the same manner as used for swelled testicle. Success often follows the application of *unguentum hydrargyri nitratis*, spread at least one-eighth of an inch thick and covered with adhesive plaster, changing every twenty-four hours.

The resulting ulcer, after expulsion of the slough, is to be treated on general principles.

## ACNE.

**Synonyms.** Acne vulgaris; acne disseminata; varus; stone-pock.

**Definition.** An inflammation, usually chronic, of the sebaceous glands; characterized by the development of papules, tubercles or pustules, or by a combination of such lesions, usually in various stages of formation, occurring for the most part upon the face.

**Varieties.** *Acne papulosa*; *acne pustulosa*; *acne artificialis*.

**Cause.** Not always understood, as the affection is frequently associated with apparently the most robust health. A frequent cause is puberty. Among the other causes observed are gastro-intestinal disorders, anaemia, chlorosis, uterine disorders, urethral irritation, scrofula, and the use of large doses of the bromides and iodides. Acne may exist alone or be associated with comedo or seborrhœa.

**Pathology.** An inflammation of the sebaceous gland structure and surrounding tissues. There first occurs retention of the sebaceous secretion, which is soon followed by hyperæmia and exudation about the glands and in the gland wall (*acne papulosa*), infiltration of the connective tissue (*acne tuberculosa*), followed by suppuration (*acne pustulosa*). If the inflammatory action be severe, destruction of the gland with a resulting cicatrix occurs.

**Symptoms.** *Acne papulosa* or *acne punctata*. This variety of the affection is the earliest stage of the inflammatory action, and is usually of short duration, being soon followed by the development of *pus*. It is characterized by the occurrence of *pin-head* to *pea-size*, *flat, more or less pointed papules*, situated about the sebaceous follicles, *lightish in color*, with a minute central black point, the opening of the sebaceous duct. Pustules are not infrequently observed scattered among the papules. The lesion is unaccompanied with either local or constitutional symptoms. While the forehead is the most frequent seat for this variety, they sometimes are seen elsewhere.

*Acne pustulosa.* This is the fully developed affection. It is seen upon the face, neck, shoulders and back, as *pin-head* to *pea-sized*, rounded or acuminate *pustules*, seated upon an infiltrated, reddish base of superficial or deep inflammatory product (*acne indurata*). Scattered among the pustules may be seen numerous papules. There are no constitutional symptoms, nor is pain complained of unless the pustule be handled.

*Acne artificialis* is rather a clinical variety, the result, usually, of large doses of the bromides or iodides, the lesion being identical with acne pustulosa.

**Diagnosis.** The lesion is so characteristic, the course so chronic, and the location so frequently upon the face, that an error seems impossible if care be exercised.

The resemblance of the papular and pustular syphiloderms must not be mistaken for acne.

**Prognosis.** Essentially a chronic affection, lasting for a number of years; but if persistent treatment be employed recovery will occur.

**Treatment.** To successfully combat an attack of acne, both constitutional and local measures must be employed.

*Constitutional treatment.* The successful treatment of a case of acne depends upon a knowledge of its cause and familiarity with the constitutional habits of the patient. Disorders of digestion and constitution should be corrected. If anaemia be present, *ferrum* and *arsenicum* are indicated. Scrofula is an indication for *oleum morrhuae* and *ferri iodidum*. Uterine disorders, if present, should receive proper attention. In young adult males I have seen wonderful improvement follow the passage of a fair-sized bougie once or twice weekly.

*Calcii sulphid.*, gr.  $\frac{1}{16}-\frac{1}{2}$ , every two or three hours, is valuable in many cases, as is *hydrargyri chloridum corrosivum*, gr.  $\frac{1}{165}-\frac{1}{65}$ , three times daily. A remedy highly spoken of by Dr. Bulkley is *glycerinum* in tablespoonful doses, two or three times daily. Dr. Duhring recommends that it be given in combination with *ferri et quininæ citras*. Prof. Bartholow "has seen excellent results from the use of *syrupus hypophosphitum comp.* in acne indurata."

*Local treatment.* In acne of not very long duration I have seen excellent results from the following plan : Just before retiring, the parts affected are to be thoroughly washed with water as hot as can possibly be borne, and after the water has partly dried the parts are to be thoroughly covered with *sulphur sublimatum*, applied by means of a powder puff ball, no rubbing or friction to be employed, and on arising in the morning the sulphur is to be washed off with hot water and the face lightly mopped dry, or what is better, sulphur again applied, if the patient is willing to permit it, during the day.

Dr. Hyde recommends that the contents of the papules and pustules be evacuated by means of a needle, rather encouraging slight bleeding, after which the parts are to be bathed with water as hot as can be

tolerated ; and while the part is still wet, it is thoroughly scrubbed with *lotio saponis viridis*, then cleansed with water, carefully dried and anointed with a *sulphur* ointment.

Prof. Bartholow suggested, in a case of *acne indurata* seen with the author, the following successful plan. To dissolve the sebaceous matter—

R. Liquor potassæ, . . . . . fʒj.  
Aqua destil., . . . . . fʒj. M.

SIG.—Applied to the acne spots *only*.

After which they were anointed with—

R. Plumbi nitrat., . . . . . gr. xv  
Ung. petrolei, . . . . . ʒj. M.

SIG.—Apply twice daily.

Dr. Duhring recommends the use of the following, after washing the parts with hot water :—

R. Sulphuris præcip., . . . . . ʒj  
Glycerini, . . . . . fʒss  
Adipis benz., . . . . . ʒj.  
Ol rosæ, . . . . . gut. iij. M.  
Ft. ung.

SIG.—To be thoroughly rubbed into the skin at night.

## ACNE ROSACEA.

**Synonyms.** Gutta rosea ; gutta rosacea.

**Definition.** A chronic hyperæmia or inflammatory affection of the nose and cheeks ; characterized by redness, hypertrophy of the skin and dilatation and enlargement of the blood vessels supplying the part, and the development of more or less acne. The nose and cheeks are the most frequent location.

**Causes.** Not always determined. It occurs in young women about puberty who are anaemic, or suffer from a general debility, nervous irritability or prostration, dyspepsia or menstrual irregularities. It often appears during the menopause. In young males the affection can often be traced to nervous or general debility, or dyspepsia. The use of spirituous liquors or of large amounts of condiments are frequent causes, as is constant exposure to the weather. It is frequently associated with seborrhœa.

**Pathology.** There first occurs blood stasis in the vessels of the part, producing the undue redness first noticed. As a result of the stasis, sooner or later the capillaries are dilated and hypertrophied, and as a result of the interrupted circulation inflammation of the sebaceous gland (acne) results, with the development of papules and pustules. This constitutes the typical acne rosacea. The affection may proceed no further, remaining at this point for years, or, rarely, the pathology of this stage is exaggerated, the involved tissues all hypertrophying, and the connective tissue undergoing a true hyperplasia, causing increased size and abnormal shape of the nose.

**Symptoms.** The onset of the affection is slow and insidious, characterized at first by more or less diffused *redness* of the part, the color aggravated by water or cold air. If the nose be the part attacked, it is usually greasy (seborrhœic), and is apt to be cool or even cold. This condition may remain for years, but sooner or later the evidence of dilatation and hypertrophy of the capillaries is apparent by the more decided and permanent redness, and upon close examination the enlarged minute cutaneous blood vessels are seen as delicate or coarse red lines, running superficially over the skin in an irregular and tortuous course. Soon are developed upon the hyperæmic and hypertrophied skin *papules* (acne papulosa) and *pustules* (acne pustulosa), their number never, however, being very great. *This constitutes true acne rosacea.* The disease may remain in this state, or, rarely, the cutaneous tissues are greatly hypertrophied, the blood vessels enormously dilated, the glands enlarged and the connective tissue undergoes hyperplasia, resulting in permanent, dark red, bulky formations, the shape of the nose being contorted into various irregular forms. Duhring reports a case in which the nose was the size of the patient's fist (*rhinophyma*).

The nose and cheeks are the usual location of the disease, although rarely it involves the forehead.

**Diagnosis.** The characteristics of the disease are so marked, consisting of rosacea—the dilated and hypertrophic blood vessels—with papular and pustular acne superadded, that an error can hardly occur, if due care be exercised.

Lupus vulgaris bears some resemblance to acne rosacea, as it is apt to develop about the face, and especially the nose; but the papules, tubercles and pustules of lupus vulgaris soon ulcerate, followed by crusts and cicatrices, which never occur in acne rosacea.

Lupus erythematosus may be confounded with acne rosacea if it occurs upon the end of the nose; but in the former the skin is harsh and covered with adherent whitish and yellowish scales connected with the openings of the sebaceous follicles, which is never the case in acne rosacea.

Frostbite resembles the first stage of acne rosacea, but the history of the two conditions soon determines the diagnosis.

**Prognosis.** Favorable, if treatment be instituted during the first stage. After hypertrophy has occurred but little can be accomplished.

**Treatment.** The cause is to be sought after and removed, and the general health to be promoted. The use of all alcoholic drinks is to be interdicted and but small amounts of tea and coffee are to be allowed. In the first stage good results may be obtained from the following formula, known as "Kummerfeld's lotion":—

R.	Sulphur præcipitat,	3 iv	
	Pulv. camphoræ,	gr. x	
	Pulv. tragacanthæ,	3 j	
	Aquæ calcis,	f 3 ij	
	Aquæ rosæ,	f 3 ij.	M.

SIG.—Shake the bottle before using and apply every few hours.

Or—

R.	Hydrargyri chlor. corrosiv.,	gr. ii	
	Ung. petrolei,	3 j.	M.

SIG.—Apply thoroughly.

Or, the following, suggested by G. H. Fox—

R.	Chrysarobini,	3 ss	
	Collodii,	3 j.	M.

SIG.—Put a brush through the cork and paint lesion every evening.

For the second stage stronger applications are usually required. The dilated capillaries should be incised with a sharp knife, in the hope that adhesive inflammation may close the calibre of the vessels, cold water compresses being used to control the bleeding, a few of the dilated vessels being thus treated every day or two, until all have been incised. Another plan is to paint the affected parts, once or twice a week, with a ten to twenty grain solution of *potassa*, following its application with an emollient poultice. Electrolysis has also been recommended.

In the third stage the knife is the only effectual remedy.

## PSORIASIS.

**Synonyms.** Lepra; alphos; psora; English leprosy.

**Definition.** A chronic affection of the skin, characterized by reddish, more or less thickened and elevated, dry, inflammatory and somewhat wrinkled patches, variable as to size, shape and number, and covered with abundant whitish or grayish-colored, imbricated scales. It is not contagious.

**Cause.** Not known. The source of the affection is, no doubt, limited to the skin itself, as no external and internal factors can produce it. It occurs in the robust and in the feeble, and in males and females. It usually first appears in early life and recurs at intervals, for years.

**Pathology.** According to Dr. A. R. Robinson, of New York, "the disease is essentially a hyperplasia of the normal constituents of the Malpighian layer (mucous layer). The increase takes place chiefly in the interpapillary portion of the layer, the growth of which downward causes an apparent increase in the size of the papillæ of the corium, which, however, on closer examination, are found not to be enlarged. In the later stages of the disease the more superficial blood vessels of the corium become dilated, a more or less considerable emigration of the white blood corpuscles takes place, and the immediate neighborhood of the vessels, together with the connective tissue of the corium, becomes the seat of a round-cell infiltration, which, with the effusion of serum, separates the connective-tissue bundles and fibres into an open mesh work. During the period of disappearance of the disease there is a gradual return to the normal condition, until the hyperplasia, dilatation of the blood vessels, and cell infiltration have completely disappeared. The hair in psoriasis is affected from the beginning of the disease, hyperplasia of the external root sheath, the structure corresponding to the Malpighian layer of the epidermis, taking place, with extension of the hyperplastic structure into the surrounding cutis. The sebaceous and sweat glands are not at any time affected."

**Symptoms.** Psoriasis begins as small, *reddish spots*, of the size of a pin's head, which immediately become covered with scanty or abundant *whitish or grayish, imbricated scales*. The spots gradually increase in diameter, forming patches of various sizes and shapes.

If one of the scales be detached by means of the finger nail, it will be found to adhere quite firmly to the skin, and to be about the thick-

ness of a card-board. If the reddish patch thus made bare be pinched up between the finger and thumb, and compared with a similar pinch of the healthy skin, its inflammatory thickening will be discerned.

*There is no watery discharge at any time.*

The skin between the patches is perfectly healthy.

While the anatomical lesions are always identical, the eruption assumes such features, as to the size and shape of the patches, as to give rise to special names.

*Psoriasis punctata.* The eruption occurs as small, rounded patches, about the size of a pin's head. This is a rare variety, as the lesion rapidly increases in size.

*Psoriasis guttata.* The eruption occurs in the form and size of drops, and when covered with scales gives the skin the appearance of having been splashed with mortar. A quite frequent variety.

*Psoriasis mummularis.* The eruption resembles variously-sized coins. This is frequently as large as the patches grow.

*Psoriasis circinata.* The eruption about the size of the former variety, the centre clearing away, leaving the skin normal, although it may continue to enlarge at the periphery, after the manner of *tinea circinata*.

*Psoriasis gyrata.* The eruption in wavy lines, of the width of about half an inch, resembling circles and semicircles. This variety is a continuation of the former, from the joining of the patches of psoriasis circinata.

*Psoriasis diffusa.* The patches of eruption are large and of irregular shape, covering a considerable amount of surface. This variety occurs more frequently on the front of the leg and the outer aspect of the forearm.

*Psoriasis palmaris et plantaris.* In these regions the eruption is characterized by larger, thicker and less lustreless scales, and by the occurrence of deep and painful fissures, from which exudes either a serous or sanguineous fluid.

*Psoriasis unguium.* In psoriasis of the nails they become thickened, opaque, grayish in color, deeply grooved transversely and often pitted, and in rare cases the nails are replaced by a scaly incrustation.

Any portion of the body is liable to be attacked with psoriasis. The only discomfort the patient suffers is the *itching*, which at times is very severe and distressing.

**Diagnosis.** A typical case of psoriasis presents no difficulty in diagnosis. There are a few affections, however, which may be confounding in irregular cases.

Eczema squamosum occurring upon the legs closely resembles psoriasis, and if the former has been attended with a very small amount of moisture and the latter has been considerably irritated by scratching, the diagnosis will be very difficult.

The papulo-squamous syphiloderm and psoriasis are frequently mistaken for each other, the diagnosis at times being extremely difficult.

*Tinea circinata* and psoriasis *circinata* resemble each other, but the patches of the latter are less inflammatory, red and infiltrated, and the scales more abundant and larger than in the former. *Tinea circinata* is usually the result of contagion, and the scales contain a fungus.

Seborrhœa of the scalp and psoriasis of the same region frequently are difficult of diagnosis. In the former the scalp is paler, the scales are finer, smaller, more generally diffused, of a grayish or yellowish color, and a greasy, sebaceous character. Psoriasis of the scalp is in patches, which are reddish and infiltrated, and there are almost always patches of the disease on other parts of the body.

**Prognosis.** An attack can usually be removed, but it is always apt to return, so that a permanent cure can never be promised.

**Treatment.** Constitutional and local measures are both needed in the majority of attacks of psoriasis.

*Constitutional treatment.* Attention to the general health, removing all deleterious influences, such as dyspepsia, constipation, lithiasis, malaria, anaemia or catarrhs.

Among the most valuable remedies used in the treatment of psoriasis is *arsenicum*, given in full doses for a long period. It is to be borne in mind, however, that the drug is contraindicated in all acute and inflammatory cases. *Chrysarobin*, gr.  $\frac{1}{8}$ , t. d., gradually increased, has been suggested, but of its utility I have had no experience. *Phosphorus, acidum carbolicum* and *pix liquida* have all been used with variable success.

*Local treatment.* The character of the local measures should be controlled by the duration of the disease, its extent, location and obstinacy.

The first step is the thorough removal of the scales. This may be

accomplished by repeated washings with soft soap and water, by either plain or alkaline baths, medicated washes or caustic ointments.

In the early stage, with highly inflammatory symptoms, soothing applications, such as water dressings or inunctions with oils, of which *oleum olivæ* rubbed over the patch several times each day is very serviceable.

For chronic cases nothing seems comparable with the following formula, suggested by Dr. G. H. Fox:—

R. Chrysarobin, . . . . . gr. x-xx-3j  
 Ætheris et alcoholis, . . . . ad . . . . q. s.  
 Collodii, . . . . . 3j. M.

SIG.—Rub the chrysarobin with a little alcohol and ether and add to the collodion.

If a camel's-hair pencil be placed through the cork, this may be painted over the affected patch after the removal of the scales, and after drying it will not stain the clothing. Care must be exercised that the strength be not too great, or a dermatitis may result.

Other local remedies are: *pix liquida*, *saponis viridis*, *creasolum*, *sulphur*, *calcium sulphuretum* and *acidum carbolicum*.

## HYPERTROPHIES OF THE SKIN.

### LENTIGO.

**Synonym.** Freckles.

**Definition.** A pigmentary deposit of the skin, characterized by irregularly-shaped, pin-head or pea-sized, yellowish, brownish or blackish spots, occurring for the most part about the face and back of the hands.

**Cause.** In the majority of instances exposure to the sun is the exciting cause.

**Pathology.** In anatomical structure freckles consist of a circumscribed, increased amount of normal pigment, differing from chloasma only in the peculiar form and size of the deposit.

**Symptoms.** The number of "freckles" varies from a very few to immense numbers. They occur as brownish or yellowish-brown, small, roundish, irregular spots, most commonly upon the face and hands. Rarely the number is very great, and they give to the skin an uncleanly appearance. They are apt to occur at all ages, but rarely before the third year.

They are unattended with itching or other subjective symptoms.

**Prognosis.** Usually favorable. Their course, when left to themselves, is chronic, lasting for years or a lifetime. They ordinarily appear in the summer, fading away as cold weather approaches, to return the following summer.

**Treatment.** The following application has been usually successful in my hands:—

R.	Hydrargyri chlor. corrosiv., . . . . .	gr. iij
	Acid. hydrochlorici, dil., . . . . .	fʒj
	Alcoholis, . . . . .	fʒj
	Glycerini, . . . . .	fʒ ss
	Aqua rosæ, . . . . ad . . . . .	fʒ iv. M.

SIG.—Apply at bedtime, and remove with soap and water in the morning.

### CHLOASMA.

**Synonyms.** Liver spots; moth.

**Definition.** A pigmentary discoloration of the skin, characterized by variously sized and shaped, more or less defined, smooth patches, or of a discoloration, yellowish, brownish or blackish in color.

**Cause.** The etiology of chloasma depends upon whether the pigmentation is idiopathic or symptomatic in its occurrence.

Idiopathic chloasma results from the irritation of long-continued scratching, such as is practiced in severe eczema or pediculosis, the application of blisters and sinapisms, heat, the direct rays of the sun, and various medicinal and chemical substances, such as follows the prolonged use of argentum (argyria).

Symptomatic chloasma occurs in connection with cancer, malaria, tuberculosis, disease of the supra-renal capsule (Addison's disease), disease of the womb, pregnancy (chloasma uterinum), neurotic disturbances, anaemia and chlorosis.

**Pathology.** The affection is an increased deposit of the normal pigment, having its seat in the mucous layer of the epidermis. The deposition of the pigment is the result of a nervous derangement, possibly of the trophic system.

**Symptoms.** Chloasma is simply a discoloration of the skin, unattended with alteration of the surface.

The patches vary in size and shape; they may be as minute as a coin or as large as the hand, or much larger, even to a universal

discoloration of the entire surface, and they may be roundish or irregular in outline.

The usual color is *yellowish, brownish or muddy*, or even *blackish* (*melasma, melanoderma*).

In *Addison's Disease*, of a typical character, "the coloration is brownish, with an olive-greenish or bronze tint, and is general, although, as a rule, especially pronounced upon regions having a disposition to normal increase of pigment, as the face, backs of the hands, axillæ, areolæ of the nipples, and the genital organs; the hair, also, may become darkened. It may, also, occur with or follow other pigmentary changes, as of the hair. Gaskoin reports a case, occurring in a woman aged forty-five, where the patch, situated on the cheek, near the nose, was intensely dark. It had existed nine years. The color of her hair had, fifteen years previously, changed from caroty-red to black." For additional symptoms, see page 367.

In *Argyria* or discoloration of the skin resulting from the internal use of nitrate of silver, the color is a bluish, bluish-gray, slate, bronze or blackish, varying as to the shade. It occurs over the surface generally, but is more pronounced upon parts exposed, as the face and hands.

*Chloasma uterinum* occurs most frequently between the ages of twenty-five and fifty, seldom after the menopause, caused, in the greater number of instances, by changes, physiological and pathological, which take place in connection with the uterus. It is seen in the married and single, although much commoner in the former. Pregnancy is the most frequent cause, although also associated with either dysmenorrhœa, chlorosis, anaemia or hysteria.

It is seen in the mildest degree about the eyelids, especially during the menstrual epoch, as a duskiness or swarthiness of the complexion, either lasting a few days or being permanent. As usually encountered, however, chloasma of this variety consists in the presence of one or several patches, appearing generally about the forehead or other parts of the face, upon the trunk, about the nipples and upon the abdomen. Rarely the entire face is covered with a discolouration, resembling a mask. Cases are recorded in which the pigmentary deposit was general, resembling Addison's disease.

**Diagnosis.** Tinea versicolor and chloasma resemble each other in the color of the patches, but otherwise they have nothing in com-

mon. Tinea versicolor occurs on the trunk, while chloasma occurs upon the face and about the nipples, and in cases the result of pregnancy, about the umbilicus, except in those comparatively rare instances in which the discoloration is diffused. The patches of chloasma are smooth, those of tinea versicolor furfuraceous, as can readily be demonstrated by gently scraping the discoloration with the finger nail.

**Prognosis.** Unless the result of Addison's disease, the prolonged use of argentum, tuberculosis or cancer, favorable.

**Treatment.** Chloasma, not the result of organic disease, or the use of argentum, is usually removed by either of the following formulæ :—

R.	Hydrargyri chloridi corrosiv., . . . . .	gr. viii
Zinci sulphat., . . . . .	3 ss	
Plumbi acetatis, . . . . .	3 ss	
Aquæ, . . . . .	f 3 iv.	M.

SIG.—Lotion. Apply morning and evening.

—HARDY.

Or—

R.	Hydrargyri chloridi corrosiv., . . . . .	gr. vij
Acidi acetici dil., . . . . .	f 3 ij	
Boracis, . . . . .	3 ij	
Aquæ rosæ, . . . . .	f 3 iv.	M.

SIG.—Lotion. Apply twice daily.

—BULKLEY.

Or—

R.	Hydrarg. ammoniat., . . . . .	3 j
Bismuthi subnit., . . . . .	3 j	
Ung. petrolei., . . . . .	3 j.	M.

SIG.—Apply frequently.

For *argyria*, the first step is the withdrawal of the argentum, and, according to Prof. Bartholow, "a persistent and long-continued use of *potassii iodidum* and *sodii hypophosphis* has, in a few fortunate instances, caused the absorption and excretion of the silver deposits. The action of these systemic remedies for the discoloration may be aided by baths of the *hyposulphites*, and by the cautious use of lotions containing *potassii cyanidum*, which possesses a decided solvent power over the silver deposits."

## CALLOSITAS.

**Synonyms.** Tyloma; callus; callosity.

**Definition.** Callositas or tyloma consists in the development of a hard or horny, thickened patch of skin, variable in extent, and of a grayish, yellowish or brownish color, and unattended with pain. The most frequent location is upon the hands and feet.

**Causes.** The result of pressure or friction, as in the case of the hands of the mechanic, the effect of his tools; or, if upon the foot, the result of ill-fitting shoes or from unusual walking. Callosities are also seen upon the fingers of violin, banjo and harp players.

**Pathology.** A hypertrophy of the horny layer of the skin, the corium remaining normal. The cells of the epidermis become so closely packed together as often to simulate horn substance.

**Symptoms.** Callositas consists in an increase in the thickness of the skin of the affected part, presenting a firm, dense, more or less circumscribed structure, the extent of hardness varying considerably, sometimes being horny. The patch of hardness is generally about the size of a coin, roundish in shape and somewhat elevated above the surrounding skin. The color of the patch may be either grayish, yellowish or brownish.

Callositas are usually upon the palms, fingers, soles and toes, although other parts, if exposed to the cause, may also be the seat. At times great pain and discomfort are experienced from the growth.

Occasionally callositas are complicated by hyperæmia, fissure, acute inflammation, abscess, erysipelas, and serve readily as foci for such cutaneous diseases as eczema and psoriasis.

**Course.** Their formation and development is always slow and gradual. If the cause be removed, the prognosis is favorable.

**Treatment.** If the removal of the callous growth be desirable, the part should be repeatedly soaked in warm water, or a poultice applied, or warmed oil kept in contact by compresses of flannel, which will soften the induration and permit its removal by paring or scraping, layer by layer, with a sharp knife. Success has been reported from the use of a plaster of india-rubber containing *acidum salicylicum*.

## CLAVUS.

**Synonym.** Corn.

**Definition.** A corn is a small, circumscribed, usually flat, deep-seated hypertrophy of the epidermis, having a horny feel, projecting slightly from the skin, painful upon pressure, situated, for the most part, about the toes.

**Cause.** Continued pressure or friction, usually from ill-fitting or tight boots or shoes.

**Pathology.** A clavus consists of a circumscribed, excessive hypertrophy of the epidermis, of the same character as occurs in callosity and of a central portion—*the core*. The core extends deeply into the tissues, in the shape of an inverted cone, the base of the cone being directed outward and appearing upon the surface as a roundish elevation, its apex resting upon the papillary layer of the corium. The core of a clavus consists of a whitish, opaque, firm, tenacious body, composed of epidermic cells, arranged in concentric laminæ.

The pain attending the presence of corns results from pressure upon the true skin by the hard core, causing irritation of the nerve filaments of the papillæ.

Corns existing between two toes are constantly bathed with the moisture of the part, which macerates and softens the formation, which thus receives the name of *soft corn*, in contradistinction to the hard corn.

**Symptoms.** Until the growth attains a considerable size no discomfort, as a rule, is felt. After, however, its depth has reached the true skin, *pain* of an intermittent character, aggravated by pressure, is the chief symptom.

Corns are often weather-sensitive, being unusually painful before, during or after the occurrence of storms, and should, therefore, not be confounded with gouty or rheumatic deposits below the skin.

**Treatment.** If freedom from these annoying formations be desired, the use of a properly-fitting foot covering must be practiced. The pressure which results in the severe pain is limited by the use of the ringed protective plasters in common use.

To remove the corn, soaking with hot water or a poultice kept in contact over night, will soften the part and permit of its ready removal with the knife.

For *soft corns*, the application of *argenti nitras*, in solid stick form, is highly spoken of, to be used after the growth has been sufficiently softened.

## VERRUCA.

**Synonym.** Wart.

**Definition.** A wart consists of a circumscribed hypertrophy of the papillary layer, with more or less epidermal accumulation, characterized by the appearance of a hard or soft, rounded, flat or acuminate formation, of variable size.

**Varieties.** The following varieties have chiefly a descriptive value: *verruca vulgaris*; *verruca plana*; *verruca filiformis*; *verruca digitata*; *verruca acuminata*.

**Cause.** Obscure. The various assigned causes are probably incapable of producing the affection.

**Pathology.** While the anatomy of warts differs somewhat according to their variety, in all forms there exist as a basis of their formation a connective-tissue growth, from which the papillary hypertrophy takes place. The interior of the growth is supplied by one or more vascular loops, from which their vitality is obtained.

**Symptoms.** The various forms are so different as to require a separate description.

*Verruca vulgaris*, or the ordinary wart, commonly seen on the hands, consists of a small, circumscribed, elevated growth, having a broad base seated securely upon the skin. Their consistency is either soft or firm, the surface smooth or rough, the color that of the surrounding skin, or yellowish, brownish or even blackish.

They may develop upon any region of the body, but are most commonly seen upon the hands and fingers.

*Verruca plana* differs from the *vulgaris* in being flat and broad in form, and but slightly raised above the level of the surrounding skin.

Their most common location is either on the back or forehead.

*Verruca filiformis* assumes the shape of a minute, thin, conical or thread-like formation, about an eighth of an inch in length.

The most frequent location is the face, eyelids and neck.

*Verruca digitata* consists of a slightly elevated, broad formation, about the size of a split pea, and marked by a number of digitations coming from its border, giving an appearance, in marked cases, resembling a crab.

Their most frequent site is upon the scalp.

*Verruca acuminata*, known, also, as the pointed wart, the moist wart, the pointed condyloma, cauliflower excrescence and venereal wart, consists of one or more groups of irregularly-shaped elevations, often so closely packed together as to form a more or less solid mass of vegetations (*verrucæ vegetantes*). Their color depends somewhat upon the degree of vascularity, varying from a pinkish, bright red to a purple color.

They occur, for the most part, about the genitalia of either sex. Upon the penis, they usually spring from the glans and the inner surface of the prepuce; the inner surface of the labia and from the vagina in the female. They are also seen about the anus, mouth, axillæ, umbilicus and toes. They may be either moist or dry, according to their location; about the genitalia, a yellowish, puriform secretion usually covers their surface, due to friction and maceration, which, owing to the heat of the parts, rapidly decomposes, producing a highly offensive, penetrating and disgusting odor.

Their size varies from that of a pea to that of an almond, an egg, or even the fist. Their development is rapid, attaining considerable size in a few weeks.

**Prognosis.** Favorable.

**Treatment.** For the smaller warts, excision by means of the knife or scissors affords the most satisfactory results. If the growth be large and likely to be attended with considerable hemorrhage, as in cases of the condyloma about the genitalia, the galvano-caustic wire, or the Paquelin cautery are to be preferred. Transfixing the growth in several directions with long needles dipped in a fifty per cent. solution of *acidum chromicum* has been recommended. The topical application of caustics, such as *acidum aceticum*, *acidum nitricum*, *argenti nitras* or *ferri perchloridum* are often satisfactory. I have been successful in some cases by painting the growth with *tinctura thuja occidentalis* until their size was considerably reduced, and then snipping them off with the scissors. The following formula for warts and corns is generally sold by pharmacists:—

R.	Acidi salicylici, . . . . .	3 ss
	Ext. cannab. indicæ, . . . . .	gr. v-x
	Collodii, . . . . .	3 ss-j.

**SIG.**—Apply once or twice daily.

An excellent formula is :—

R. Acdi salicylici,  
 Acdi boracici, . . . . . aa . . . . . gr. xv  
 Hydrargyri chlor. mite, . . . . . gr. x. M.  
 SIG.—Sprinkle over twice daily.

## ICHTHYOSIS.

**Synonyms.** Ichthyosis vera ; fish-skin disease.

**Definition.** Ichthyosis is a congenital, chronic deformity or hypertrophic disease of the skin, characterized by dryness, harshness or general scaliness of the skin, or, in the outgrowth of larger masses of a corneous consistency.

**Varieties.** *Ichthyosis simplex* ; *ichthyosis hystrix*.

**Cause.** Often hereditary, but not in all cases. It is to be regarded as an affection which is born with the individual, although it does not usually manifest itself until after the first or second year of life.

**Pathology.** "The diseased, or, better, deformed skin is found microscopically to be hypertrophied in various degrees, according to the development of the malady ; the proliferation of its elements occurring in the connective tissue, papillæ, stratum corneum and blood vessels. In well-marked cases of ichthyosis hystrix, the elongated papillæ are surmounted by dense cones of the horny layer of the epidermis, more or less concentrically disposed, with sclerosis of the connective tissue and a relatively unchanged rete. In this last particular the dense plaque of ichthyosis differs in texture from the wart." (Hyde.)

**Symptoms.** Ichthyosis displays a wide variation in its symptoms. In one individual it amounts to but a slight inconvenience, while in another it may manifest itself in so pronounced a manner as to be the source of great discomfort and deformity. The two varieties named represent merely accentuated types of the disorder, rare in its fullest development, and, in its slightest, much more common than is generally believed.

A simple dryness and harshness of the skin, with only slight furaceous exfoliation, is termed *xeroderma*.

*Ichthyosis simplex* is the more common variety, consisting of a harsh, dry condition of the whole surface, accompanied by the pro-

duction of variously sized and shaped reticulated scales, either small, thin and furfuraceous, like bran, or large and thick, resembling fish scales. Upon the extremities the scales usually form diamond-shaped or polygonal plates, separated from one another by furrows or lines, which extend down to the normal skin. In color the scales are either whitish, grayish or yellowish, and often have a silvery or glistening appearance. Rarely the color is olive-green or blackish (*ichthyosis nigricans*). The amount of scaling depends upon the age of the patient, and the duration and severity of the disease.

*Ichthyosis hystrix.* With or without the developments of the above variety, in this, the hypertrophy of the skin may occur in circumscribed patches or large areas, consisting of irregularly-shaped, verrucous, corneous, corrugated, wrinkled or rugous masses, usually darker in color than those of the simple variety. They may occur upon the arms, as solid, warty patches, or upon the back, in the form of elongated, linear patches. They may constitute roughened, corrugated, papillary growths, or uneven, horny, blunt or pointed, spinous, warty formations. In the latter case the elevations may reach several lines or more, and stand out from the skin like quills upon the back of a porcupine—hence the name *hystrix*. The amount and extent of the hypertrophy varies; the older the patient the more highly developed it will usually be.

**Course.** *Ichthyosis simplex* may involve the entire surface uniformly or appear more marked on the extremities, from the hips to the ankles and the arms and forearms. The affection is always worse in winter than in summer; the increased activity of the sweat glands at this season producing the most beneficial results. The course of the affection is essentially chronic, continuing throughout life, now better, now worse. Slight itching usually occurs.

**Diagnosis.** The characteristics of the affection are so peculiar that an error in diagnosis is hardly possible. It is to be distinguished from the inflammatory affections of the skin which terminate in desquamation, by the absence of any history of inflammation.

**Prognosis.** While much can be done to alleviate the affection, the prognosis is unfavorable as regards permanent relief.

**Treatment.** Local measures are alone of value for ichthyosis. The maceration of the accumulated masses of epithelial hypertrophy is accomplished by water baths, either simple or medicated. The relief thus afforded the patient, while temporary, is comforting.

Duhring says: "It may be stated, then, that, as a rule, the more frequently the ichthyotic patient bathes, and the longer he is able to remain in the water, the less will the deformity show itself." Vapor and alkaline baths are also serviceable. Another valuable agent is *sapo mollis* in conjunction with baths, or alone, as a discutient. For severe cases, "a sufficient quantity is to be rubbed into the skin twice daily, for four or six days, during which period the patient is to refrain from bathing. A bath is first to be taken four or five days after the last rubbing, when, in fact, the epidermis has begun to peel off; afterward inunction with a simple ointment is to be applied, in order to prevent fissuring of the new skin."

The following is a useful formula:—

R.	Adipis benz., . . . . .	$\frac{3}{j}$	
	Glycerini, . . . . .	$\frac{m}{xl}$	
	Ung. petrolei, . . . . .	$\frac{3}{ss}$	M.

SIG.—Apply daily, after washing or bathing.

—DUHRING.

Or—

R.	Potassii iodidi, . . . . .	gr. xx	
	Olei bubuli,		
	Adipis, . . . . . aa . . . . .	$\frac{3}{ss}$	
	Glycerini, . . . . .	$\frac{3}{j}$	M.

SIG.—Apply after bathing.

—MILTON.

## PARASITIC DISEASES OF THE SKIN.

### TINEA FAVOSA.

**Synonyms.** Favus; porigo favosa; honeycombed ringworm.

**Definition.** A contagious affection of the skin, due to a vegetable parasite—*Achorion Schönleinii*; characterized by the development of either discrete or confluent, small, circular, cup-shaped, pale yellow, friable crusts, usually perforated by hairs.

**Cause.** The presence and growth of a vegetable parasite known as the *Achorion Schönleinii* is the cause of tinea favosa. It is commoner in children than in adults, attacking the former, in the first place, either *de novo* or through direct contagion, and is from them communicated to adults. It is a disease confined almost exclusively to the lower classes. It is rare in the United States.

**Pathology.** Tinea favosa may have its seat either in the hair

follicle and hair, or upon the surface of the skin or the nails; the former, however, are the structures most commonly attacked.

It is purely a local affection, due solely to the presence and growth of the vegetable parasite discovered by Schönlein, of Berlin, in 1839, and named after him—*Achorion Schönleinii*. The crusts are made up almost entirely of fungus, which is seen, upon section, with the naked eye, to be composed of a porous mass and to possess a pale-yellow or whitish color. Under the microscope it is seen to consist of both mycelium and spores in great quantity, and in all stages of development.

**Symptoms.** When the affection attacks the hairs and follicles it is termed *tinea favosa pilaris*, when the epidermis, *tinea favosa epidermis*, and when the nails, *tinea favosa unguium*. Rarely all the structures may be attacked at one and the same time; its usual seat, however, is the scalp.

The disease begins by the development of one or of several *pin-head-sized, pale-yellow crusts*, seated about the hair follicles. In about a fortnight these crusts have increased in size and are umbilicated, termed the *favus cups*, are circumscribed, circular in form and very slightly elevated above the level of the skin.

In their normal condition they are of a pale-yellow or sulphur-yellow color, but after a time, from dust and other matters, they become brownish- or greenish-yellow in color. The number of crusts vary from a very few to immense numbers. The usual size is about that of a split-pea. In *tinea favosa pilaris et capitis* the affection is often accompanied with pediculi, while swelling of the glands of the neck and small abscesses upon the scalp are not uncommon. The hairs become lustreless, opaque, brittle, and at times split longitudinally, and from atrophy of the follicles and sebaceous glands permanent baldness may result.

In *tinea favosa unguium* the nails become thickened, yellow, opaque and brittle.

The disease has a peculiar *odor*, resembling that of *mice*, or of *musty, stale straw*.

**Diagnosis.** In a recent case the characteristic favus cups, the pale-yellow color, the odor and the history of contagion, should render the diagnosis easy. If of long standing, however, and the favi destroyed by scratching, some doubt may exist; but if a small fragment of a crust be placed upon a glass slide with a drop of

*liquor potassæ*, covered with a thin glass and placed under a microscope with a power of from two hundred and fifty to five hundred diameters, the features of the *Achorion Schönleinii* will determine the affection to be tinea favosa.

**Prognosis.** Tinea favosa of the epidermis readily responds to treatment. Tinea favosa pilaris is more obstinate, and if of long duration may result in baldness.

**Treatment.** The general health, in the majority of instances, requires tonics. Cleanliness is essential to successful management.

For *tinea favosa pilaris et capitis*, two remedies are essential—*parasiticides* and *depilation*. The hair should be cut as short as possible, the crusts removed by the use of oil, or soap and hot water, or poultices, again well oiled and the hairs removed by means of broad-bladed forceps, a few hairs being removed at a time and only a small surface cleared at each sitting, when the following lotion is to be thoroughly applied :—

R. Hydrarg. chlorid. corrosiv., . . . . .	gr. v-x
Ammonii chlorid. pur., . . . . .	$\frac{2}{3}$ ss
Misturæ amygdalæ amar., . . . . .	$\frac{2}{3}$ iv. M.

SIG.—Apply thoroughly.

—BULKLEY.

Or—

R. Sulphur, . . . . .	$\frac{2}{3}$ j
Hydrarg. ammoniat., . . . . .	gr. xx
Ung. petrolei, . . . . .	f $\frac{2}{3}$ j. M.

SIG.—Rub in well.

Tinea favosa of non-hairy parts requires the removal of the crusts and the application of either of the above formulæ.

### TINEA CIRCINATA.

**Synonyms.** Tinea trichophytina corporis; herpes circinatus; ringworm of the body.

**Definition.** A contagious, parasitic affection of the skin, due to the *trichophyton fungus*; characterized by the development of one or more circular or irregularly-shaped, variously-sized, inflammatory, slightly vesicular or squamous patches, occurring upon the general surface of the body.

**Cause.** Ringworm of the body is caused by the presence of a

vegetable parasite discovered by Bazin, in 1854, termed the *trichophyton*, the same growth or fungus that produces tinea tonsurans and tinea sycosis. The affection is highly contagious, and is frequently communicated from one member of a family to another, although it has been determined that a certain unknown condition of the skin is requisite for its development. In children it is most frequently seen among the weakly and poorly nourished. In adults it is usually associated with a decline in the general health.

**Pathology.** The fungus is seated between the strata of the epidermis, more particularly in the superior layers of the rete. The presence of this foreign body produces the subsequent phenomena—a superficial dermatitis, erythema, exudation, minute vesiculation and papulation, and, in the severe grades, tubercles and pustules. The desquamative symptoms are exfoliative—nature's efforts for relief.

**Symptoms.** Tinea circinata varies greatly in the degree of its development, from the trivial complaint so often seen in children to the chronic, extensive and obstinate disease sometimes seen about the thighs in adults (*tinea circinata cruris*).

The disease usually begins as a small, reddish, scaly, rounded or irregularly-shaped spot of papules, which, in a very few days, assumes a circular form (ringworm). It continues to increase in size, the papules often changing to vesicles. A characteristic of the eruption is its healing in the centre as it spreads on the periphery. Occasionally the circles or rings coalesce, forming serpiginous lesions. The usual size of a fully developed ringworm is about that of a silver quarter of a dollar.

Chronic tinea cincinata does not present the characteristic annular form, but "are usually in the form of single or multiple, disseminated, small, reddish, slightly scaly, ill-defined spots, on a level with or but slightly raised above the surrounding skin. Not infrequently they are the size of a small or large finger nail, and are irregularly shaped, and, as a rule, without line of demarcation."

The "eczema marginatum" of Hebra is to be looked upon as a severe form of tinea circinata.

*Tinea circinata cruris*, or ringworm of the thighs, a variety of the "eczema marginatum of Hebra," is usually complicated with true eczema, and is a very obstinate, chronic form of the affection; it is accompanied by severe itching.

*Tinea trichophytina unguium* is a rare variety. The nails become

opaque, whitish, thickened and soft and brittle, especially along their free border. The microscope is essential for a diagnosis. Its course is chronic, and it is difficult to cure.

**Course.** As commonly seen, ringworm is very amenable to treatment. Occasionally, however, it exhibits great obstinacy, showing itself repeatedly in the same region, in the form of relapses, or manifesting itself from time to time in new localities.

**Diagnosis.** Tinea circinata may be mistaken for squamous or other varieties of eczema, but the circular and often annular form, the well-defined margin, the slight desquamation and the course and history of ringworm should prevent error. Chronic ringworm is more difficult, however.

Seborrhœa and psoriasis often assume a somewhat circular form, and then have a resemblance to ringworm; but a study of the clinical history should render the diagnosis easy.

All doubtful points in diagnosis should be determined by the microscope. The examination can readily be made in the following manner: "A few of the scales may be scraped, with a blunt knife blade, from the suspected patch and placed upon a glass slide containing a drop of liquor potassæ, over which is laid a thin glass cover. The cover should be pressed down and the epidermic mass flattened out. Permitting the specimen to remain for a few minutes, it may be viewed with a power of from two hundred and fifty to five hundred diameters. The fungus will, in most cases, be detected here and there, having at first a faint outline, but becoming more distinct as the specimen stands."

**Prognosis.** Favorable, as a rule, although the affection is rebellious to treatment in some instances and prone to relapses.

**Treatment.** Local treatment is usually all that is required for the cure of tinea circinata. In the majority of instances the following plan will be successful. Washing the patch with soft soap and water and the application of one of the following ointments:—

R. Cupri acetat., . . . . . gr. x  
 Ung. aquæ rosæ, . . . . . ʒj. M.  
 SIG.—Keep in contact with the patch.

Or—

R. Hydrargyri ammoniat., . . . . . gr. xx-xxx  
 Ung. petroeli, . . . . . ʒj. M.  
 SIG.—Keep in contact with the patch.

"In obstinate tinea circinata cruris the following, recommended by Tilbury Fox, may be employed :"—

R.	Creasoti, . . . . .	m <sub>xx</sub>
	Olei cadini, . . . . .	f <sub>3</sub> ij
	Sulphuris sublimati, . . . . .	3 ij
	Potassii bicarb., . . . . .	3 j
	Adipis, . . . . .	3 j.

M.

SIG.—Keep in contact with the affection.

### TINEA TONSURANS.

**Synonyms.** Tinea trichophytina capitis; herpes tonsurans; ring-worm of the scalp.

**Definition.** A *contagious*, parasitic affection of the scalp, due to the *trichophyton fungus*; characterized by the development of circumscribed, vesicular or squamous, more or less bald patches, showing the hair to be diseased and usually broken off close to the scalp.

**Cause.** The result of the presence and growth of the same fungus giving rise to tinea circinata—*trichophyton*. It is an affection of childhood, seldom being seen after puberty. It is highly contagious, and may be communicated from a case of ringworm of the body.

**Pathology.** The parasite originally named "*trichophyton tonsurans*" invades the hair, hair follicles and epidermis of the scalp, the hair, however, suffering the most severely, becoming in a short time filled with the growth to such an extent, usually, as to cause its disintegration and destruction. The hair follicle, also, becomes distended and prominently raised. The hair shaft is fractured just above the level of the scalp, and usually presents a jagged, bristly, stubble-like extremity. The epidermis of the scalp may either present the changes of minute vesicles and desquamation, or in severe cases, oedema and inflammatory symptoms, with fluid exudation (*tinea kerion*).

**Symptoms.** Ringworm of the scalp usually begins in the form of small circumscribed patches, which soon become the seat of small vesicles or pustules, which terminate in desquamation, or of furfuraceous scales. The patches spread rapidly, soon reaching the size of a silver quarter to that of a silver dollar. They are circular in form, circumscribed, of a reddish, grayish or greenish-yellow color, covered with fine or coarse scales, with the hairs broken off close to the scalp. The epidermis of the scalp is more or less raised and the follicles are

prominent, giving the characteristic appearance of the disease—the goose-skin or plucked-fowl appearance. As a result of the loss of hair, baldness, more or less complete, but temporary, exists.

*Itching*, slight or severe, is a constant symptom.

Ringworm of the face or body (*tinea circinata*) may complicate tinea tonsurans.

Chronic ringworm of the scalp is the same condition in a more chronic form, having existed for six months to a year or two.

*Tinea kerion* is a severe variety of tinea tonsurans, "characterized by œdema, inflammation, and the exudation of a viscid, glutinous, yellowish secretion from the opening of the hair follicles. When fully developed the patches are yellowish, reddish or purplish in color, and are more or less raised, œdematosus and boggy. They are uneven and honeycomb-like (whence the name kerion), and studded with yellowish, suppurative points, or, later, with small cavities or foramina, the openings of the distended hair follicles deprived of their hairs, which discharge a mucoid, gummy, honey-like fluid."

The patches are tender, painful and at times the seat of itching. The course of the affection is chronic.

**Diagnosis.** The diagnosis is usually unattended with difficulty, if the characteristic circumscribed vesicular or scaly patches with stubby hair be present.

Squamous eczema somewhat resembles tinea tonsurans, but the hairs are normal in eczema and firmly embedded in the follicles, while they are almost always stumpy in ringworm, and in those cases in which they are not broken off, if pulled, they easily fall out. Ring-worm is contagious, eczema is not.

Alopecia areata presents a white, shiny, ivory-like, bald patch, devoid of scales, eruption, or hair. Ringworm has the vesicular or scaly patch with broken-off hairs.

In any case of doubt the microscope will readily determine the diagnosis, if "one or two of the short stumpy hairs should be placed upon a slide with a drop of *liquor potassæ* and permitted to stand a few minutes, when, under a power of two hundred and fifty diameters the fungus, as well as the lesions of the hair, will be visible."

**Prognosis.** Favorable, although obstinate in chronic cases. Relapses are of frequent occurrence.

**Treatment.** Local measures are satisfactory in the majority of instances of tinea tonsurans.

Mild cases should be treated by cutting the hair as close as possible and thoroughly scrubbing the patches with *sapo viridis* and water and the application twice daily of a six per cent. solution of *oleatum hydrargyri*, or either of the following :—

R. Sodii horat., . . . . .	3ij.	
Aceti destil., . . . . .	3ij.	M.

SIG.—Apply thoroughly several times daily.

Or—

R. Acidi boracici, . . . . .	gr. xv	
Sulphur. flor., . . . . .	gr. xv	
Vaselini, . . . . .	f 3 iss.	M.

SIG.—Apply morning and night.

Or, use may be made of Morris' thymol solution, to wit :—

R. Thymol, . . . . .	3 ss	
Chloroformi, . . . . .	3 ij	
Ol. olivæ, . . . . .	3 vj.	M.

A preparation very popular in London, known as Coster's paste, is used by painting the patches with a brush and allowing it to remain on until the crust is cast off, in the course of five or six days, when it may be reapplied. A few applications often suffice. Its formula is—

R. Iodi, . . . . .	3 ij	
Olei picis, . . . . .	f 3 ij.	M.

The iodine and oil of tar should be gradually and slowly mixed.

An excellent application in rebellious cases is—

R. Potassæ (caustic), . . . . .	gr. ix	
Acid carbolici, . . . . .	gr. xxiv	
Lanoline, . . . . .	3 ss	
Ol. theobromæ, . . . . .	3 ss.	M.

SIG.—A small amount rubbed into head night and morning. If the scalp is not shaved the application is retained better.

Cases which resist these means are to be treated by removing the loose hairs about the edges of the patches, and the broken-off hairs over the surface, by means of small, broad-bladed, short forceps, a few hairs only being seized at a time; a portion of the diseased hairs to be removed each day until the surface has been cleared. After each depilation, one of the above formulæ are to be applied.

## TINEA SYCOSIS.

**Synonyms.** Tinea trichophytina barbæ; sycosis parasitica; barbers' itch; ringworm of the beard.

**Definition.** A *contagious*, parasitic affection of the hair, hair follicles and subcutaneous tissues of the hairy portion of the face and neck in the adult male, due to the *trichophyton fungus*; characterized by the development of tubercles and pustules.

**Cause.** Tinea sycosis is the result of the presence and growth of the same vegetable parasite that causes tinea circinata and tinea tonsurans—*trichophyton*—which invades the hair follicle and hair. It is highly contagious, and is said to be acquired, in most cases, at the hands of the barber (?). It is not a very common affection. Like the other vegetable growths, it seems to require some peculiar, unknown condition of the skin for its development. It may develop from a case of tinea circinata or develop simultaneously with it.

**Pathology.** The parasite finds its way into the hair follicles and attacks the root and shaft of the hair, causing inflammation, followed by more or less follicular suppuration and general infiltration of the surrounding tissues. The irritation caused by the presence of the fungus results in inflammation of the subcutaneous connective tissue and the well-known tubercular formations peculiar to the affection. They are firm, comparatively painless, and manifest but little disposition to undergo change, remaining during the presence of the fungus and finally gradually disappearing without leaving a scar. Under the microscope the parasite is plainly discernible.

**Symptoms.** Barbers' itch begins as an attack of tinea circinata—as one or more reddish, scaly patches. Soon the redness and desquamation become more decided, attended with swelling and induration. The hairs will also be dry, brittle, incline to break, and many of them are already loose. The process rapidly increases, the skin becomes distinctly nodular and lumpy, and points of pustulation develop about the openings of the hair follicles. The subcutaneous connective tissue is also involved, giving rise to thick, firm masses of induration.

The surface has a dark red or purplish color, and is studded with variously-sized tubercles and pustules. In some instances the number of tubercles are in excess, while in others the pustules are more numerous, numbers of them discharging, and are succeeded by thick crusts, which are often so abundant as to simulate pustular eczema.

The hairs are always diseased, and break off, either in the follicles or just above the level of the surface. Those not breaking drop out, leaving the region partly or wholly devoid of hair.

The most frequent location attacked is the chin, neck and submaxillary region. One or, what is more common, both sides of the face are involved.

*Itching, burning pain and swelling* always accompany the affection, varying in intensity from moderate to very severe.

The course of the affection is usually chronic. Relapses are frequent, unless most thoroughly eradicated.

**Diagnosis.** *Sycosis non-parasitica* occasions difficulty of diagnosis at times. The points of difference, however, are usually so marked that error should not occur.

*Sycosis non-parasitica* is a chronic, inflammatory, *non-contagious* affection of the hair follicles, characterized by the development of papules and pustules, which are perforated with hairs, the hairs themselves being unaffected. The upper lip, cheeks and chin are the parts mostly involved. If of long duration, some inflammatory thickening results.

In *tinea sycosis* or *sycosis parasitica*, the skin and subcutaneous connective tissue are extensively involved, as manifested by the induration and formation of the characteristic tubercles. The upper lip is rarely invaded, the hairs are diseased, broken off or loose, and under the microscope reveal the parasite.

*Pustular eczema* resembles *tinea sycosis*, with extensive pustulation and crusting. But in the former the hairs are not involved, nor are the characteristic tubercles present.

**Treatment.** Local measures are sufficient for the cure of *tinea sycosis*. In the majority of instances the following procedure will effect a cure in three or four weeks. If crusts are present, and almost always some are, they are to be thoroughly saturated with inunctions of almond or olive oil, and removed by washing with soft soap and water. The part is then cleanly shaved, the first operation being more painful than subsequent ones. After shaving, the affected surface is bathed for ten minutes in water as hot as can be borne. All pustules are then opened with a fine needle, after which the parts are sponged freely for several minutes with a solution of *sodii hyposulphitis*,  $\frac{3}{j}$ , *aquæ*,  $f\frac{3}{j}$ , after which the parts are again thoroughly washed with hot water, carefully dried and smeared with an *unguentum sulphur.*, containing  $3j$ - $ij$  to the ounce. This procedure is

preferably performed at night. The following morning the ointment is washed off with soap and water, the face bathed with the sodium solution, and dusted with any inert powder. This plan continued faithfully every night, omitting the shaving when the beard has not grown much, will usually be followed with success.

Cases resisting the above means should, in addition to the above, have the hairs depilated, the shaving performed every two or three days, thus allowing time for the hairs to grow sufficiently to depilate, the operation seldom being so painful as one would suppose. Shaving and depilation upon alternate days should be faithfully practiced until the new hairs show themselves to be healthy.

In addition to the parasiticides mentioned, any of those recommended for the other vegetable parasitic diseases may be used.

### TINEA VERSICOLOR.

**Synonyms.** Pityriasis versicolor; liver-spots.

**Definition.** A *contagious*, parasitic affection of the skin, due to the *microsporon furfur*; characterized by the occurrence of variously sized, irregularly-shaped, dry, slightly furfuraceous, yellowish spots upon the chest or other portions of the body.

**Cause.** Pityriasis versicolor is the result of the presence upon the surface of the skin of a vegetable fungus termed the *microsporon furfur*. It is a mildly contagious affection seen after puberty. It is said to occur most frequently in those suffering from wasting diseases, particularly *phthisis pulmonalis*. It is not connected with any affection of the liver, as supposed by the laity.

**Pathology.** The fungus permeates the horny layer of the epidermis, never the hair or nail, and gives rise to the irregular-shaped and sized maculæ, of a yellowish or brownish color. As a rule, it gives rise to neither hyperæmia nor inflammatory symptoms.

**Symptoms.** Tinea versicolor occurs in the form of irregular, roundish, circumscribed or reticulated maculæ. The spots vary in size from that of a small silver coin to that of the hand. By coalescing they often cover a greater portion of the chest, their most usual site. Upon close inspection the surface of the macule is seen to be covered with furfuraceous scales, and if the scales be not visible, scraping with the finger nail will demonstrate their presence. In color the spots vary from a delicate buff or fawn shade to a yellowish,

deep brown, and, rarely, even blackish hue. At times mild itching accompanies the eruption.

**Diagnosis.** The characteristics of the eruption are so distinct that errors in diagnosis can hardly occur. If any doubt exist, a few of the scales placed upon a glass slide, with a drop of *liquor potassæ*, and covered with a thin glass cover and placed under a microscope with a power of from two hundred and fifty to five hundred diameters, the fungus is readily discerned.

**Prognosis.** Favorable.

**Treatment.** The parts should be cleansed with soap and water, and either of the following lotions applied :—

R.	Sodii sulphitis, . . . . .	3 ij	
	Glycerini, . . . . .	f 3 ij	
	Aquæ, . . . . . ad . . . . .	f 3 iv.	M.

SIG.—Apply frequently.

Or—

R.	Hydrargyri chlorid. corrosiv., . . . . .	gr. iv	
	Alcoholis, . . . . .	f 3 vj	
	Ammonii muriat., . . . . .	3 ss	
	Aquæ rosæ, . . . . . ad . . . . .	f 3 vj.	M.

SIG.—Apply frequently.

—TILBURY FOX.

## SCABIES.

**Synonym.** The itch.

**Definition.** A contagious, animal parasitic disease of the skin, due to the *acarus* or *sarcoptes scabiei*; characterized by the formation of cuniculi (burrows), papules, vesicles and pustules; followed by excoriations, crusts and general cutaneous inflammation, and accompanied with itching.

**Cause.** Contagion. The only cause is the presence of the animal parasite, the *acarus* or *sarcoptes scabiei*. The affection occurs at all ages and in every walk in life.

**Pathology.** Scabies is an inflammation of the skin with the development of papules, vesicles, pustules, excoriations and subsequent crusting, the result of the ravages of the animal parasite, together with the irritation produced by the scratching of the patient.

The parasite—*acarus* or *sarcoptes scabiei*—is a minute creature, barely visible to the naked eye as a yellowish-white, rounded body. The female is the most commonly met with, the males being said to

take no part in causing the affection, and so are rarely seen. They are said to die in about a week after copulation with the female. The female finds her way by boring through the horny layer into the mucous layer of the epidermis, and, being impregnated, begins at once laying her eggs and at the same time making her burrow. A variable number of eggs are deposited, usually about a dozen, after which she perishes in the skin. The ova hatch out in eight or ten days.

**Symptoms.** Scabies being an artificial dermatitis or eczema, according to the amount of irritation produced by the presence of the parasite and the traumatism the result of the severe scratching of the patient.

Immediately upon the arrival of the itch mite upon the skin it begins its work of burrowing, and very soon a burrow or *cuniculus* is formed, in which the eggs are deposited, and which also becomes the habitat of the female during the remainder of her life. The ova are hatched in about one week after their deposit, and they at once begin to care for themselves and to burrow, resulting in the formation of as many additional *cuniculi* as there are active female mites. It is the presence of these burrowing parasites that constitutes the irritation resulting in the inflammation of the skin, characterized by the formation of minute *papules*, *vesicles* and *pustules*, with more or less inflammatory induration. Add to these the *excoriations*, *scratch marks*, *fissures*, *torn vesicles*, and *pustules with yellow and bloody crusts*, caused by the scratching, and a picture of the fully-developed disease is seen.

The *burrow*, or *cuniculus*, as it is termed, is formed by the mite entering and making its way beneath the horny layer of the epidermis, which is raised, very much as a mole undermines the ground. It occurs as a slight linear elevation of the epidermis, varying from a half a line to four or five lines in length, and having an irregular or tortuous course. Its color is whitish or yellowish, speckled here and there with dark dots. At either end the *cuniculus* terminates as darkish points, the more prominent of which represent the parasite.

The *papules* are the first inflammatory lesion, are numerous, and of small size, and may be the extent of the disease.

The *vesicles* are the next stage, varying in size and number, having an inflamed base, sometimes presenting cunicula upon their summits.

The *pustules* represent the completion of the inflammatory action, their size and number varying with the severity of the irritation.

The *intense itching*, which is worse at night, results in excoriations, torn papules, vesicles and pustules, followed by crustings, which after a time disguise the characteristic lesions. The regions of the body attacked are the hands, especially the sides of the fingers and the folds where they join the hands. After a time the wrists, penis and mammae, and around about and upon the nipples, are invaded.

Persons predisposed to eczema have this affection developed in addition to the simple dermatitis, by the ravages of the itch mite.

**Diagnosis.** A case of scabies seen before irritated by scratching presents no difficulty in diagnosis. The presence of the burrows always suffices for the diagnosis, but these are not always discoverable. The location of the eruption always points strongly to scabies. A history of contagion is of value. All doubt can be set at rest by the aid of the microscope.

**Prognosis.** Always favorable, relapses only occurring when the treatment has been imperfectly carried out or where the individual has re-contracted the disease.

**Treatment.** Local measures are alone required in the treatment of scabies. The strength of the parasiticides must be controlled by the severity of the inflammatory symptoms present. If eczema complicate scabies, it is to be treated as an ordinary attack after the death of the itch mites.

Scabies always succumbs to the following plan. The patient is to be thoroughly washed with soft soap and water, followed by a warm bath, after which one of the following ointments is to be thoroughly rubbed into every portion of the body, special attention being devoted to the hands, fingers and other parts usually the seat of the disease.

R. Styrcis liquidis, . . . . .	3 ij	
Ung. sulphuris, . . . . .	3 ij-iv	
Ung. petrolei, . . . . . ad	3 j.	M.

SIG.—Apply after washing.

—BULKLEY.

Or—

R. Sulphuris sublimat., . . . . .	3 j	
Balsam. Peruviani, . . . . .	3 ss	
Adipis, . . . . .	3 j.	M.

SIG.—For children.

—DUHRING.

## PEDICULOSIS.

**Synonyms.** Phthiriasis ; morbus pedicularis ; lousiness.

**Definition.** A *contagious*, animal parasitic disease of the head, body or pubes, due to the presence of pediculi and characterized by the wounds inflicted by the parasite, together with excoriations and scratch marks.

**Varieties.** *Pediculosis capitis* ; *pediculosis corporis* ; *pediculosis pubis*.

**Cause.** The cause is the presence of the parasite, the result of contagion, direct or indirect. The view of "a spontaneous generation" of pediculi is not accepted by the great majority of observers.

**Pathology.** The lesion produced by the presence of the pediculi is a minute hemorrhage, caused by the parasite inserting its sucking apparatus, or, as it is termed, its haustellum, into a follicle, and obtaining blood by a process of sucking, and not by biting, as is generally supposed. The presence of the parasite in any great numbers brings about a peculiar irritable state of the skin, which gives rise to an irresistible desire to scratch, as a consequence of which the surface is markedly excoriated and lacerated.

**Symptoms.** The symptoms which arise from the presence of the parasite in different localities are somewhat different, and call for separate consideration.

*Pediculosis capitis.* This variety is caused by the presence of the *pediculus capitis* or head louse. The *ova*, or *nits*, are readily recognized at a distance. Their favorite seat is the occipital region, either upon the surface of the scalp or upon the hair. Their presence gives rise to considerable irritation, itching and consequent scratching, resulting in the wounding of the scalp, with oozing of a serous or purulent fluid mixed with blood, which soon mats the hair and forms into crusts. In those predisposed to eczema, the presence of the parasite will give rise to that condition.

The general health is usually unaffected by the presence of the pediculi.

*Pediculosis corporis.* This variety of pediculosis is caused by the presence of the *pediculus corporis* or body louse, or more properly termed the *pediculus vestimenti* or clothes louse. Its color, when devoid of blood, is dirty-white or grayish, with a dark line around the margin of its abdomen. Its habitat is the clothing covering the

general surface, remaining upon the skin only long enough to obtain sustenance. The ova are usually deposited in the seams of the clothing, the lice being hatched within the week. Occasionally a few of the pediculi may be observed crawling about the surface, or in the act of drawing blood. As they move over the surface they give rise to an intensely disagreeable itching sensation, to relieve which the patient scratches, which in turn gives rise to the characteristic lesions of the affection.

The *lesions* are numerous. The scratch marks are scattered here and there, either long and streaked, in other places short and jagged; the excoriations and blood crusts varying in size from a pin head to a split pea or even larger, with irregularly-shaped pustules. In addition to the lesions resulting from the scratching, are seen the *primary* lesions, consisting of minute reddish puncta with slight areolæ, the points at which the parasite has drawn blood. In cases of long standing, a brownish pigmentation of the whole skin may result from the long-continued irritation and scratching. The favorite site of the lesions are the back, especially about the scapular region, the chest, abdomen, hips and thighs.

Pediculosis is seen most commonly among the poorer classes, and especially the middle-aged and elderly.

*Pediculosis pubis.* This variety of pediculosis is caused by the presence of the pediculus pubis or crab louse. Although having its seat of predilection about the pubes, it may also infest the axillæ, sternal region in the male, beard, eyebrows and even eyelashes.

They may be found crawling about the hairs, but more commonly hugging the surface closely. They infest adults chiefly, and occasion symptoms similar to those described in connection with other species. They are usually contracted through sexual intercourse, although occasionally they are present in cases in which they have not been communicated in this way, and where no explanation as to the mode of contagion can be suggested. The *itching* varies from slight to severe.

**Diagnosis.** When violent itching exists in any case, without marked eruption, the possibility of the presence of pediculi should always be entertained, and if carefully sought after are found.

**Prognosis.** Favorable, if the treatment be thoroughly carried out.

**Treatment.** Local measures alone are all that is necessary for the removal of the various forms of pediculosis.

*Pediculosis capitis.* The most effective application for this variety is to thoroughly soak the head two or three times a day with ordinary petroleum or kerosene oil, and keep it wrapped in a cloth for twenty-four hours. At the end of this time the head should be thoroughly washed with soft soap and hot water, dried and saturated with the official *unguentum hydrargyri ammoniati*. If required, this entire procedure may be repeated, but usually any pediculi escaping the petroleum are destroyed by the unguentum.

*Pediculosis corporis.* In this variety the habitat of the parasite being the clothing, they must be boiled or baked at a temperature sufficiently high to destroy life. After this the clothing should be changed every day or two, carefully inspected, and if pediculi are seen they must again be baked or boiled. It is folly to expect satisfactory results unless these directions be faithfully adhered to. For the irritation, itching and excoriations, mild alkaline baths or lotions of *acidum carbolicum* are sufficient.

*Pediculosis pubis.* The parts should be washed twice daily with soft soap and water, after which the thorough application of *tinctura coccus indicus*, full strength or diluted, or a lotion of *hydrargyri chloridum corrosivum* or *unguentum hydrargyri ammoniati* will be effectual.



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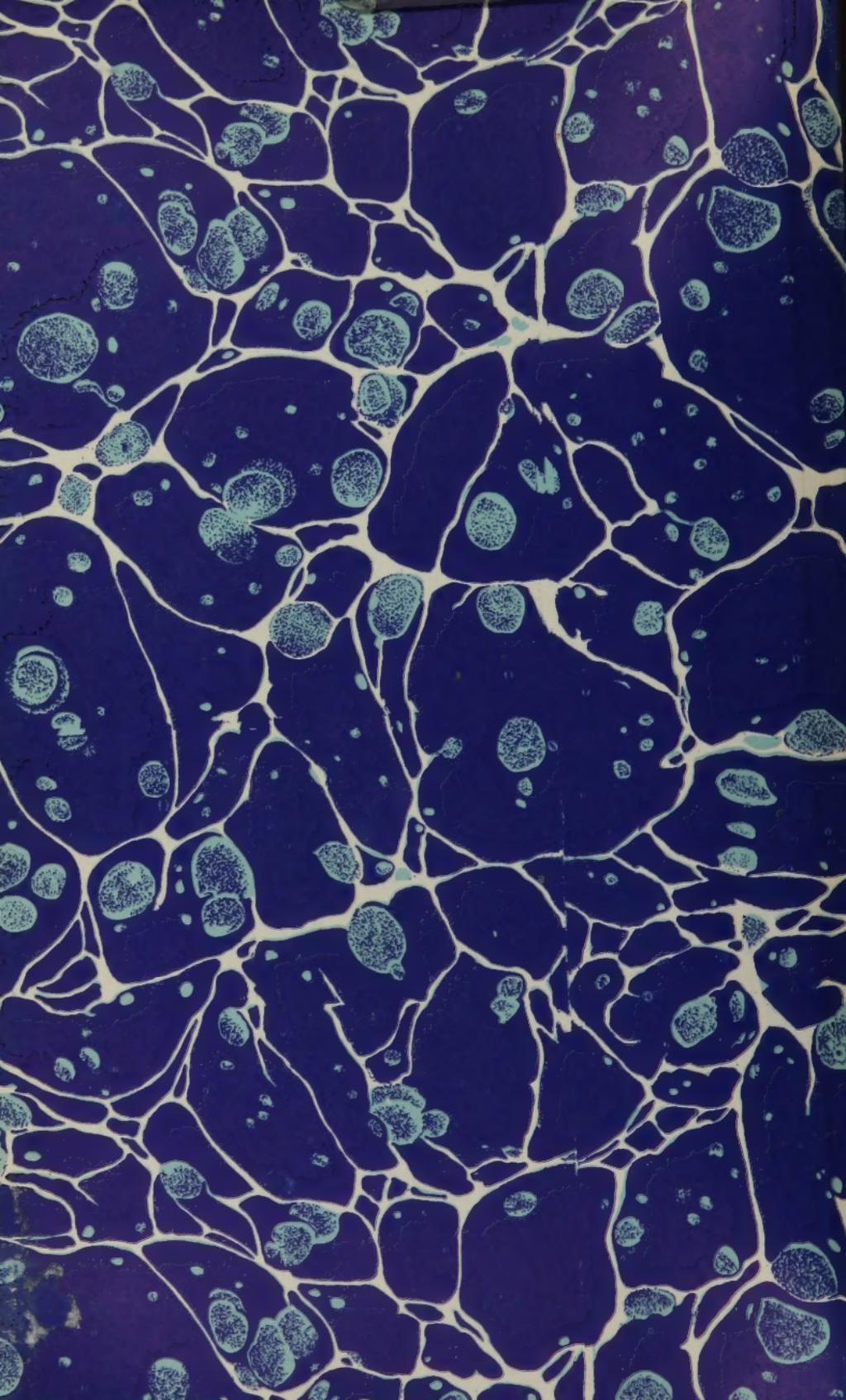


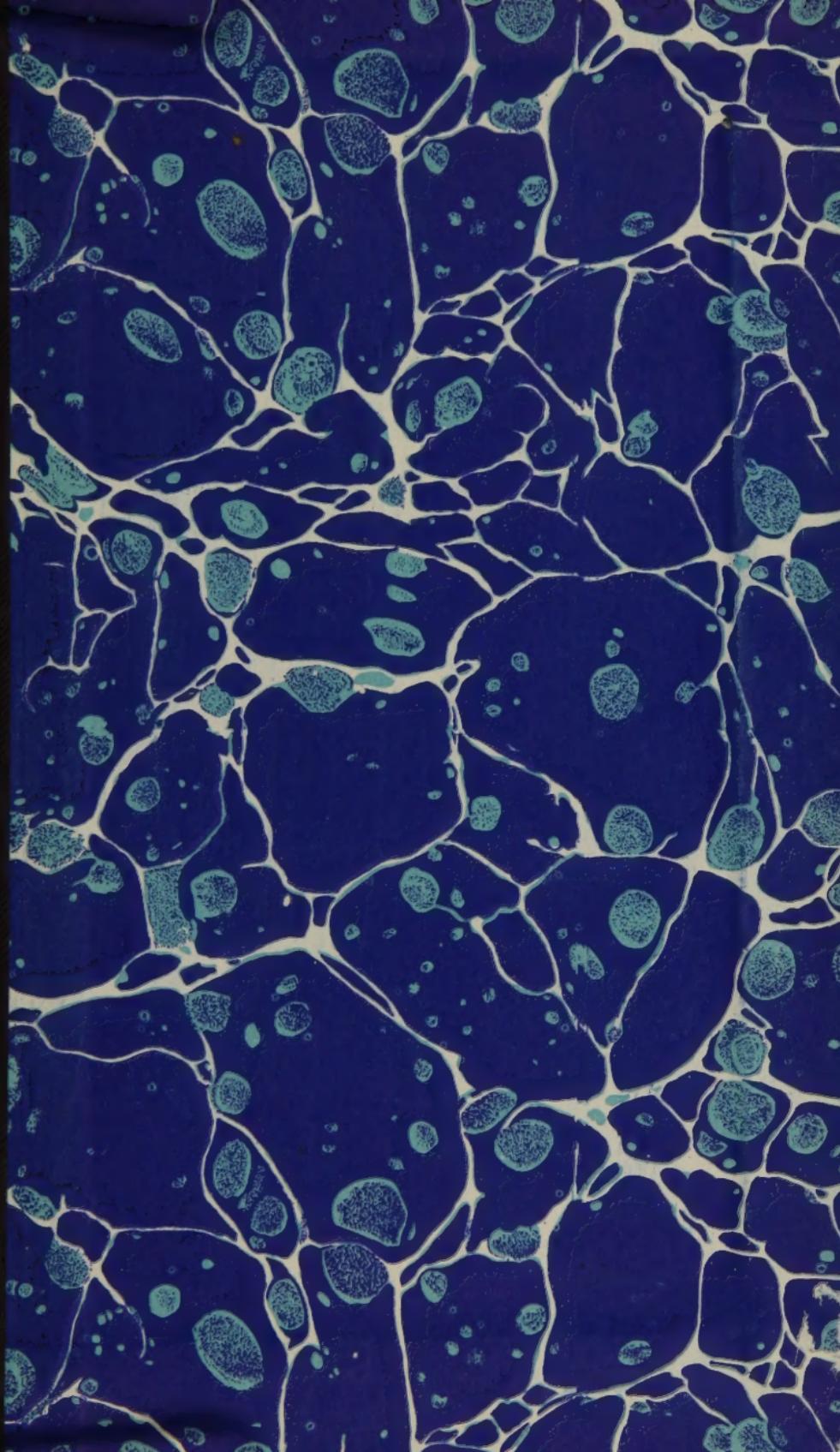












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